Massachusetts Medical Society

MMS Policy Compendium

Includes Policies Through
The 2023 Interim Meeting

Massachusetts
Medical Society

MASSACHUSETTS MEDICAL SOCIETY
POLICY COMPENDIUM
(1978–2023)

This edition of the *Massachusetts Medical Society Policy Compendium* presents the policy positions of the Society as of the close of business at the 2023 Interim Meeting of the House of Delegates.

This volume contains only permanent policies adopted by the MMS House of Delegates. It does not contain items that were referred to the Board of Trustees (items referred for decision* or report back that were *adopted* are included), filed, tabled, or not adopted; MMS bylaws, appointments, awards, or commendations. Please consult, as appropriate, the *Massachusetts Medical Society Acts of Incorporation and Bylaws* or the *Massachusetts Medical Society House of Delegates Proceedings* for this information. ***Please note:** beginning with the 2016 Annual Meeting, items referred to the Board of Trustees for decision that were adopted and accepted by the House of Delegates are noted with the Board and House meeting dates that the actions were taken.

This volume is arranged alphabetically, by major subject headings. Under each subject heading, the most recent policies are listed first. Noted at the end of each statement is the date that the House of Delegates voted on the policy.

We hope this edition of the *Massachusetts Medical Society Policy Compendium* is a valuable resource for members and staff. For further information on policy making at the Society, please contact the Department of Governance Meetings and Services.

Barbara Spivak, MD	Melody Eckardt, MD, MPH, FACOG	Eli Freiman, MD, FAAP
President	Speaker	Vice Speaker

/at

PURPOSES OF THE MASSACHUSETTS MEDICAL SOCIETY

The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit, and welfare of the citizens of the Commonwealth.

— Section 2, Acts of Incorporation, 1781

As referenced in Bylaws, Chapter 1, 1.00

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ABORTION

Abortion

The MMS will advocate for legislation that would increase appropriate access to abortion services. *(D)*

The MMS will advocate for legislation and policies that would allow performance of abortions after 24 weeks of pregnancy in cases of lethal fetal anomalies. *(D)*

(Approved MMS Board of Trustees, 8/28/19)
Accepted MMS House of Delegates, 12/7/19

The Massachusetts Medical Society adopts the following (items 1 and 3 adapted from American Medical Association):

That the American Medical Association supports access to preventive and reproductive health services for all patients and opposes 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.

Abortion is an essential medical component in the continuum of reproductive health care and should be safely accessible in a collaborative, team-based model of care through physicians and appropriately trained and credentialed medical professionals in conformance with standards of good medical practice, respecting the rights of providers who are conscientious objectors - to withdraw from abortion cases when it is safe to do so. *(HP)*

No physician, other professional personnel, hospital, nor hospital personnel shall be required to perform an act violative of good medical judgement or personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.
(HP)

MMS Council, 1011/89
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20
Reaffirmed MMS House of Delegates, 12/10/22

The MMS will advocate for legislation and policies that would provide that the only criteria needed to consent to abortion are pregnancy and medical decision-making capacity. *(D)*

The MMS will advocate for legislation and policies that would expand existing safety net health coverage for pregnancy-related care to abortion. *(D)*

The MMS will advocate for legislation and policies that would update pregnancy and abortion-related medical terminology used in legal codes to reflect the most recent scientific evidence and knowledge. *(D)*

MMS House of Delegates, 5/4/19

Abortion and Contraception *(Please See Additional Policies Under Reproductive Health, Contraception)*

The MMS supports the primacy of the physician-patient relationship and access to evidence-based reproductive medicine, including mifepristone. *(HP)*

The MMS will strongly condemn Walgreens pharmacy chain for their singular action to make mifepristone unavailable without any change in FDA regulation or specific judicial action. *(D)*

The MMS opposes actions taken to limit access to evidence-based medication and condemns any judicial action that undermines the authority of the US Food and Drug Administration to review and approve drugs based on scientific evidence of efficacy and safety. *(HP)*

The MMS will work with appropriate stakeholders to advocate to codify the right to abortion derived from Roe v. Wade into federal law. *(D)*

MMS House of Delegates, 5/13/23

The MMS recognizes that health care, which is inclusive of reproductive health services such as contraception and abortion as provided under established evidence based medical indications, is a human right. *(HP)*

The MMS opposes the imposition of criminal or civil penalties or other retaliatory efforts against physicians or other health care workers or health systems that assist in, refer patients to, or provide reproductive health services including abortion. *(HP)*
The MMS opposes any criminal or civil penalties or other retaliatory efforts against patients who seek reproductive health care in Massachusetts, and those patient advocates and organizations that support them, regardless of their state of origin. *(HP)*

The MMS supports legal protections for patients who cross state lines into Massachusetts to receive reproductive health services including contraception and abortion. *(HP)*

M*MS House of Delegates, 12/10/22*

Self-Induced Abortion
The MMS will advocate against any legislative efforts or laws in Massachusetts or federally to criminalize self-induced abortion. *(D)*

MMS House of Delegates, 4/28/18
(Item 2 of Original: Auto-Sunset: Time-Limited Directive Completed MMS House of Delegates, 4/28/18)

ACCIDENT PREVENTION

Safety Belts
The Massachusetts Medical Society (MMS) strongly supports use of safety belts and child safety seats in motor vehicles. *(HP)*

The MMS encourages its members and all health care practitioners to discuss the importance of safety belt and child safety seat/restraint use as an integral part of routine health maintenance visits. *(HP)*

The MMS supports education in the public and private sectors to assist all citizens in understanding the need to wear safety belts. *(HP)*

The MMS supports the most recent guidelines developed by the American Academy of Pediatrics regarding infant and child safety seats and restraining devices. *(HP)*

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society shall advocate for functioning seat belts in all passenger seats in taxicabs and ride sharing services. *(D)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)/HUMAN IMMUNODEFICIENCY (HIV)/BLOOD-BORNE PATHOGENS

HIV/AIDS

The Massachusetts Medical Society (MMS) adopts policies on HIV and AIDS as follows:

HIV/AIDS as a Global Public Health Priority

The MMS:

(a) Strongly urges, as a public health priority, federal agencies (in cooperation with medical and public health associations and state governments) to develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic.
(b) Supports adequate public and private funding for all aspects of combating the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease.
(c) Supports national and international campaigns for the prevention of HIV infection and care of persons living with the disease.
(d) Encourages cooperative efforts among state and local health agencies, with the involvement of the MMS as appropriate, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care.
(e) Supports increased availability of antiretroviral drugs and drugs to prevent active tuberculosis infection for countries where HIV/AIDS is pandemic
(f) The MMS supports the efforts of federal and state agencies to increase access to quality care for women and children who are HIV-positive.

HIV/AIDS Reporting and Confidentiality

Information regarding an individual's HIV serostatus or related information collected in accordance with public health surveillance must not be disclosed for other purposes. There must be uniform protection at all levels of government of the identity of those with HIV infection or disease. Information collected about an individual's HIV status in the clinical setting should be used only for appropriate medical care.

Discrimination Based on HIV Seropositivity

(a) The MMS recognizes the continued discrimination against HIV-infected individuals and condemns any act and opposes any legislation of categorical discrimination based on an individual's actual or presumed disease, including HIV infection. There should be vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV health status in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate based on disease.
(b) The MMS opposes discrimination with regard to access to health care for persons who are seropositive or at risk of HIV infection. 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.
(c) The MMS supports a federal policy change to ensure blood donation bans or deferrals are applied to donors according to their individual level of risk and are not based on sexual orientation alone.

Reporting of HIV-, HBV-, and HCV-Infected Physicians

The MMS opposes mandatory reporting of HIV-, HCV-, and HBV-infected physicians to state licensing boards.

Medical Care of HIV-Infected Patients

(a) The MMS encourages patients who are HIV seropositive or at risk of HIV infection to make their condition known to their physicians and other appropriate health care providers in order to promote access to appropriate medical care and treatment.
(b) Physicians are encouraged to routinely educate all patients about the necessity of the physician obtaining a sexual and substance abuse history.
(c) MMS endorses the incorporation of HIV prevention into the medical care of persons living with HIV. The MMS joins medical and public health organizations in encouraging effective prevention strategies including the use of condoms, pre-exposure prophylaxis of high-risk populations, limitations on breast feeding, abstinence, limiting number of partners, human sexuality education programs, etc., for reducing the risk of HIV/AIDS and other sexually transmitted diseases among the population.

(d) The MMS encourages the promotion of awareness, screening, and treatment for mental disorders (including but not limited to anxiety, depression, dementia, cognitive disorders, and substance abuse disorders) among people living with HIV/AIDS. Such screening and treatment should also be promoted among caregivers of those with HIV/AIDS.

Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases
Health insurance and/or disability policies of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.

HIV/AIDS Education
(a) The MMS endorses the age-appropriate education of students regarding basic knowledge of HIV infection and recommended risk-reduction and anti-discrimination strategies.
(b) The MMS also supports the development of a federal and/or state HIV/AIDS health education program targeted to patients and the public in a linguistically and culturally-appropriate manner.
(c) The MMS supports continuing medical education instruction for practicing physicians in advances in AIDS care and HIV prevention strategies. Medical institutions should also ensure that medical students and residents are provided the basic clinical science and social issues associated with HIV infection.

HIV/AIDS and Substance Abuse
The MMS urges federal, state, and local governments to increase funding for drug treatment so people who are living with substance use disorders have immediate access to appropriate care regardless of their ability to pay. The MMS supports the availability of evidence-based treatment options and harm-reduction strategies. The MMS endorses the Centers for Disease Control's recommendations that pre-exposure prophylaxis (PrEP) be considered as one of several prevention options for persons at very high risk of HIV acquisition through injection of illegal drugs.

HIV and Travel Restrictions
The MMS opposes travel restrictions based on HIV status.

HIV, Sexual Assault, and Violence
The MMS believes that HIV testing should be offered to all victims of sexual assault and domestic violence, and that strict confidentiality of test results should be maintained.

Disease Prevention and Health Promotion in Correctional Institutions
The MMS encourages state and local health departments to develop plans to foster closer working relations between the criminal justice, medical, and public health systems to enhance medical care, health promotion, and the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis in correctional settings. The MMS recommends that education and prevention counseling be made available to persons in correctional institutions.

Control of HIV in Healthcare Settings
The MMS encourages further research to assess the risk of HIV transmission from patients to physicians and other healthcare workers. The MMS will advocate for legislative/regulatory changes to ensure immediate testing of the source individual for human immunodeficiency virus (HIV) and hepatitis B and C viruses in any occupational setting (including but not limited to needle-stick injuries) where an exposure to blood or other potentially infectious material has occurred, and for the release of those test results to the exposed individual.

Screening and Testing Standards
The MMS approves of HIV screening/testing upon admission to a healthcare facility as deemed appropriate by the attending physician. Screening should be voluntary, such that the patient has the option to opt out of such screening or testing. Permission to screen or release information that HIV testing was performed or the results of such testing should not require separate written consent; general healthcare consent forms should incorporate consent to HIV screening and release of HIV-related information. Prevention counseling should not be part of such a screening/testing program. Positive HIV test results should be appropriately reported to the relevant public health agencies.

HIV-Related Health Disparities
Recognizing the existence of gender, race, and ethnicity disparities in new HIV infections and access to health care for these HIV/AIDS patients, the MMS supports research and policy initiatives aimed at reducing healthcare disparities among HIV/AIDS patients. The MMS encourages improving access to health care for populations disproportionately

affected by HIV. The MMS supports continued efforts by the Centers for Disease Control and Prevention in its efforts to evaluate the effectiveness of HIV prevention programs in minority populations. Physicians providing HIV care should make a strong effort to provide linguistically and culturally appropriate care. (HP)

MMS House of Delegates, 11/4/06
Amended and Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The MMS will advocate at the state level for equitable access to evidence-based screening, specifically routine, universally offered testing for HIV and hepatitis C utilizing verbal consent for people entering the jails and prisons in the Commonwealth. *(D)*

The MMS will advocate at the state level to ensure that the Commonwealth of Massachusetts allocates adequate resources to jails and prisons for testing for HIV and hepatitis C as well as counseling. *(D)*

The MMS will advocate at the state level to ensure that patients at risk of HIV infection in the jails and prisons be offered continuation of pre-exposure prophylaxis and post-exposure prophylaxis, or access to initiation of pre-exposure prophylaxis and post-exposure prophylaxis. *(D)*

The MMS will advocate that the healthcare staff of the jails and prisons receive a basic degree of training around the prevention and testing of HIV and hepatitis C, specifically routine, universally offered testing. *(D)*

The MMS will advocate at the state level to ensure that patients diagnosed with HIV and/or hepatitis C are directly referred to treatment upon release from jails and prisons. *(D)*

MMS House of Delegates, 12/4/21

Procedural Consent Documents
The MMS will work with appropriate organizations to promote adoption by hospitals and other healthcare organizations of admission and procedural consent documents that inform the patient that testing for HIV and other blood-borne pathogens, such as hepatitis B and hepatitis C, will be performed in the event of an occupational exposure of a healthcare worker to the patient's blood or body fluids. This would best be accomplished by addition of a separate provision to the "blanket" informed consent forms signed by patients on admission to hospitals or outpatient facilities, which will stipulate that the results of such testing will be released to the patient and that appropriate counseling will be provided by a qualified physician, in the event of a positive result.

The form also will inform the patient that the results will be released to the exposed healthcare worker for the sake of providing appropriate preventive measures. This separate provision must clearly state that refusal to grant permission for testing will not in any way jeopardize the care provided to the patient by the healthcare organization or any of its staff or professional employees. *(D)*

MMS House of Delegates, 4/28/18

ADVANCE CARE PLANNING/END-OF-LIFE CARE

Advance Care Planning
The MMS defines advance care planning as an individual's consideration of values and goals for medical care throughout the life span, with expectation for these choices to change over time. Advance care planning includes ongoing conversations with an individuals' loved ones, surrogate decision-makers, and physicians and other health care providers. The process includes completion of certain legal documents including health care proxies and, for some, medical orders such as the MOLST form. Decisions may also include becoming an organ donor. (HP)

MMS House of Delegates, 5/8/21

The MMS, in collaboration with other appropriate entities, will propose legislation to address the need to expedite the medical decision-making process for patients lacking capacity who do not have a health care proxy. *(D)*

MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The MMS will lead the physician education component of the Massachusetts Implementation Guide, which will reflect the improved governing structure and key implementation components of the national POLST form. *(D)*

The MMS will conduct an online webinar on the use of the Massachusetts version of the national POLST form. *(D)*

The MMS will support the statewide implementation of the Massachusetts version of the national POLST form. *(D)*
MMS House of Delegates, 12/7/19
(Item 1 of Original: Auto-Sunset, Time-Limited Directive Completed: MMS House of Delegates, 12/5/20)

The MMS will continue to support the use of Medical Orders for Life Sustaining Treatment (MOLST) in Massachusetts, including providing education to Massachusetts providers regarding MOLST forms. *(D)*

The MMS encourages the ongoing work of the Massachusetts Department of Public Health and other stakeholders to meet the National Physician Orders for Life Sustaining Treatment (POLST) Paradigm, which includes a section on limited medical intervention for the seriously ill and frail patient. *(D)*

MMS House of Delegates, 4/28/18
(Item 3 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 5/4/19)

The MMS will work with the Mass Serious Illness Coalition and the State Legislature to find ways to encourage completion of health care proxies, (for example, by providing a Health Care Proxy form as part of driver licensure and renewal. *(D)*

The MMS will work with the Mass Serious Illness Coalition and the State legislature to create a Health Care Proxy registry, available to physicians, other providers, and appropriate entities, with 24/7 secure access. *(D)*
MMS House of Delegates, 4/29/17

The MMS, in collaboration with other appropriate entities, will propose legislation to address the need to expedite the medical decision-making process for incompetent patients lacking a health care proxy. *(D)*
MMS House of Delegates, 5/17/14
Amended MMS House of Delegates, 5/8/21

The Massachusetts Medical Society will continue to work with hospitals, medical schools, and other interested organizations to develop and promote educational materials to improve physician and patient knowledge of and implementation of health care proxies beginning at age 18 and continuing throughout the life span. *(D)*

The Massachusetts Medical Society will continue to work with hospitals, medical schools, and other interested organizations to develop public education materials and programs to improve understanding of and increase utilization of advance directives, health care proxies and other appropriate health care documents, palliative care, and policies and procedures that uphold the individuals' choice, goals, and values throughout life. *(D)*
MMS House of Delegates, 5/19/95
Reaffirmed MMS House of Delegates, 5/31/02
Item 1: Reaffirmed MMS House of Delegates, 5/8/09
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates, 4/29/17

In order to support physicians in their efforts to help patients and their families to plan for serious illness and end-of life care in advance, the Massachusetts Medical Society (MMS) encourages its members to routinely discuss values and goals of care with patients in consideration of health care proxies, MOLST and eMOLST medical orders, and other advance directives. *(HP)*

The MMS continues to promote and disseminate educational information to assist its members with having the difficult conversations concerning serious illness and end-of-life care with patients and their families. *(HP)*
MMS House of Delegates, 5/18/07
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/17/14
Item 2: Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society will work with organizations with expertise to provide facilitated and informed decision-making by patients, their proxies, and their families regarding responses to code status, end-of-life, and life sustaining treatment. *(HP)*

The MMS will educate and communicate best practices regarding code status, end of life, and life sustaining treatment discussions with patients, to physicians and others on the care team, to support appropriate electronic sharing of such patient information, and, if needed create more comprehensive guidelines for physicians to follow, when having code status, end-of-life, and life sustaining treatment discussions with patients. *(D)*

MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society endorses the concept that individuals be allowed to maintain control of their treatment by executing a written document specifying instructions and desires regarding their medical care, and that the Society make available to medical practitioners in the Commonwealth information about such documents. *(HP)*

MMS Council, 5/18/90
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The MMS will work with the Massachusetts Hospital Association and other appropriate entities to develop a means to expedite medical decision-making and health care access for incompetent patients who lack a health care proxy, such as expedited judicial review or changes to probate code. *(D)*

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

The Massachusetts Medical Society endorses and encourages statewide dissemination and adoption of the Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) Program, which assists individuals in communicating their preferences for life-sustaining treatments near the end of life. (*HP)*

The Massachusetts Medical Society will continue to support continuing medical education appropriate for risk management credit that includes information to assure that clinicians can work with appropriate patients to communicate their preferences for life-sustaining treatment across health care settings, document these preferences on a Massachusetts Medical Orders for Life Sustaining Treatment (MOLST) form, and respond appropriately when they encounter a patient with a MOLST form. *(D)*

MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 4/28/18
Amended (duplication of 4/18) and Reaffirmed MMS House of Delegates, 5/4/19

End-of-Life Care

The MMS defines medical aid-in-dying as the act of providing care — palliative, hospice, compassionate — to patients at the end of life. The act of a physician writing a prescription for a lethal dose of medication to be used by an adult with a terminal illness at such time as the patient sees fit will, if legalized, be recognized as an additional option in the care of the terminally ill. *(HP)*

The MMS adopts the position of neutral engagement, serving as a medical and scientific resource to inform legislative efforts that will support patient and physician shared decision making regarding medical aid-in-dying, provided that physicians shall not be required to provide medical aid-in-dying that involves prescribing lethal doses of medication if it violates personally held ethical principles. *(HP)*

The MMS asserts that medical aid-in-dying that involves prescribing lethal doses of medication should be practiced only by a duly licensed physician in conformance with standards of good medical practice and statutory authority. *(HP)*

The MMS will support its members regarding clinical, ethical, and legal considerations of medical aid-in-dying, through education, advocacy, and/or the provision of other resources, whether or not members choose to practice it. *(HP)*

The MMS supports effective palliative care, especially at the end of life. *(HP)*

MMS House of Delegates, 12/2/17
(Item 5 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 4/28/18)
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society supports the following principles for the provision of comprehensive care for individuals with advanced serious illness:

Whole-person care, including the evolving physical, emotional, social, and spiritual needs of individuals, as well as those of their family and/or caregivers

Promotion of equity and opposition to discrimination in care, including race, age, culture, socioeconomic status, and meaningful communication with family and other caregivers despite potential isolation or language barriers

Synergy in medical and social elements of care that integrate health care and long-term services and supports which may reduce hospitalizations and health care costs while improving patients' quality of life

Basic palliative care skills wherein health professionals are prepared to deliver primary pain and symptom management to patients who are not currently hospitalized or do not require specialty palliative care

Public awareness regarding the meaning of serious illness to encourage advance care planning and informed choice based on the needs and values of individuals

Informed preferences for care and treatment that are in line with a person's values, goals, condition, circumstances, and needs, with the acknowledgement that individual service needs and intensity will change over time
(HP)

The MMS will provide members and the public, via existing communication venues, information on legislative issues that may affect access to person-centered, family-oriented care that enhances autonomy and choice at the end of life. *(HP)*
MMS House of Delegates, 12/6/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society recognizes the autonomy rights of patients with advanced, chronic illness, including dementia, and/or persons who do not have decision-making capacity who have previously expressed their wishes to refuse treatment including the use of intravenous fluids and gastrointestinal feeding by tube and that implementation of these wishes by a physician does not in itself constitute unethical medical behavior provided that appropriate medical and family or surrogate decision maker consultation is obtained. (HP)
MMS Council, 7/17/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The MMS will sponsor ongoing continuing medical education opportunities that address end-of-life care and pain management and their implications for risk management, and host a section on the MMS website for resources and reference information on these topics. *(D)*
MMS House of Delegates, 12/3/06
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/11/13
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society supports patient dignity and the alleviation of pain and suffering at the end of life. *(HP)*

The Massachusetts Medical Society will provide physicians treating terminally ill patients with the ethical, medical, social, and legal education, training, and resources to enable them to contribute to the comfort and dignity of the patient and the patient's family. *(D)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 12/3/11
(Item 3 of Original: Rescinded MMS House of Delegates, 12/2/17)
Reaffirmed MMS House of Delegates, 4/18/18

AGING

Nursing Homes/Skilled Nursing Facilities
The MMS strongly urges physicians who wish to serve as medical directors in skilled nursing facilities to have education, training, or certification appropriate for the role. *(HP)*

MMS House of Delegates, 12/9/23

The Massachusetts Medical Society will investigate and take appropriate action through educational and legislative means to facilitate appropriate state and federal funding to improve the status of patient care in nursing homes. *(HP)*
MMS House of Delegates, 11/6/00
Amended and Reaffirmed MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society will advocate for law, regulation, or guidance providing that doctors and other providers in nursing homes and skilled nursing facilities are exempt from consulting the prescription monitoring program or MassPAT except at the time of discharge from the facility. *(D)*

(Approved MMS Board of Trustees, 2/7/18)
Accepted MMS House of Delegates, 4/28/18

ALCOHOL

Underage/Dangers
The MMS supports educational and outreach efforts within the framework of the Society's existing publications and communications, highlighting to the public the dangers of underage drinking and driving. *(HP)*

The MMS shall work with the appropriate state government agencies to draft legislation minimizing alcohol promotions, advertising, and other marketing strategies by the alcohol industry aimed at adolescents. *(D)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Item 1 of Original: Amended and Reaffirmed MMS House of Delegates, 5/2/15
Item 1 of Original: Sunset MMS House of Delegates, 5/12/22
Amended and Reaffirmed MMS House of Delegates, 5/13/23
(Item 2: To Be Reviewed at A-24)

ALLIED HEALTH PROFESSIONS AND SERVICES

OB/GYNs and Certified Nurse-Midwives
The Massachusetts Medical Society (MMS) adopts the following statement regarding relationships between obstetrician-gynecologists and certified nurse-midwives*:

The MMS recognizes that in those circumstances in which obstetrician-gynecologists and certified nurse-midwives work together in the care of women, the quality of those practices is enhanced by a working relationship characterized by mutual respect and trust as well as professional responsibility and accountability. When obstetrician-gynecologists and certified nurse-midwives work together, they should concur on a clear mechanism for consultation, management, and referral based on the individual needs of each patient.

Recognizing the high level of responsibility that obstetrician-gynecologists and certified nurse-midwives assume when providing care to women, the MMS supports and encourages communication and collegial relationships between physicians and certified nurse-midwives. *(HP)*

*Certified nurse-midwives are registered nurses who have graduated from a midwifery education program accredited by the American College of Nurse Midwives (ACNM) Division of Accreditation and have passed a national certification examination administered by the ACNM Certification Council, Inc.

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/15/10
Reaffirmed MMS House of Delegates, 4/29/17

Physicians and Physician Assistants
The Massachusetts Medical Society adopts the following guidelines regarding the relationships of physicians and nurse practitioners:

a) The physician is ultimately responsible for managing the health care of patients in all practice settings.

b) Health care services delivered in a collaborative practice must be within the scope of each practitioner's professional license, as defined by state law.

c) In a collaborative practice with a nurse practitioner, the physician and nurse practitioner will coordinate care and ensure the quality of health care provided to patients.

d) The extent of involvement by the nurse practitioner in assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition, as determined by the physician and nurse practitioner.

e) The role of the nurse practitioner in the delivery of care should be defined through mutually agreed upon guidelines for care that are developed by the physician and the nurse practitioner.

f) These guidelines for care should delineate the appropriate involvement of the two professionals in the care of patients, based on the complexity and acuity of the patient's condition.

g) A physician must be available for consultation with the nurse practitioner at all times, either in person, through telecommunication systems, or other means.

h) Patients are to be made clearly aware at all times whether they are being cared for by a physician or a nurse practitioner.

i) In a collaborative practice, there should be a professional and courteous relationship between physician and nurse practitioner, with mutual acknowledgment of and respect for each other's contributions to patient care.

j) Physicians and nurse practitioners should review and document, on a regular basis, the care of all patients with whom the nurse practitioner is involved. Physicians and nurse practitioners must work closely enough together to become fully conversant with each other's practice patterns.

Physicians and Physician Assistants
The Massachusetts Medical Society adopts the following guidelines regarding the relationships of physicians and physician assistants:

a) The physician is ultimately responsible for managing the health care of patients in all settings.

b) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice as defined by state law.

c) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

d) The physician is responsible for the supervision of the physician assistant in all settings.

e) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines for care that are developed by the physician and the physician assistant, and based on the physician's delegatory style.

f) The physician must be available for consultation with the physician assistant at all times either in person, through telecommunication systems, or other means.

g) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training and experience and preparation of the physician assistant as adjudged by the physician.

h) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

i) There should be a professional and courteous relationship between physician and physician assistant, with mutual acknowledgment of and respect for each other's contributions to patient care.

j) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for care.

k) The physician is responsible for clarifying and familiarizing the physician assistant with the physician's supervising methods and style of delegating patient care.

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
(Physicians and Physician Assistants) Reaffirmed MMS House of Delegates, 4/28/18
(Physicians/Nurse Practitioners: Sunset MMS House of Delegates, 4/28/18)

Radiological Technologists
The MMS will express support of measures that promote patient protection and health care workers safety in the appropriate and cost-effective use of fluoroscopic medical services. *(HP)*

MMS House of Delegates, 5/14/04
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 4/28/18

Registered Nurses/Physician Assistants
The home services of a registered nurse or a physicians' assistant providing health care under the direct control, supervision and employment of a duly registered physician are deemed services reimbursable to the physician through any payment mechanism, i.e., self pay, public or third party.

MMS Council, 10/9/74
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Scope of Practice
The MMS will advocate in legislative forums where allied health professionals seek to provide the same or similar services as a physician with no, limited, or reduced oversight structures, that said individuals be subject to the same statutory and regulatory mandates with regard to the provision of those services, including but not limited to residency requirements, professional liability insurance requirements, continuing education mandates, and adjudicatory and discipline standards. *(D)*

(Approved MMS Board of Trustees, 10/11/17)
Accepted MMS House of Delegates, 12/2/17

The MMS only supports an entity's attempt to increase its scope of practice if: (1) the entity has proven a clear and distinctly identifiable public purpose and benefit, and; (2) has proposed legislation that addresses appropriate supervision, meaningful educational requirements, public protections, and practice standards. *(HP)*

MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

AWARDS

The Massachusetts Medical Society (MMS) adopts the following general guidelines for recognition awards:

a) Nomination of a current member of an MMS committee for an award that the MMS committee recommends is prohibited.

b) Awards need not be presented each year.

(HP)

MMS House of Delegates, 5/7/16
(Item 2 of Original: Auto-Sunset)
Reaffirmed MMS House of Delegates, 5/13/23

BLOOD DONATION

Blood Donation

The Massachusetts Medical Society will continue its efforts to encourage the voluntary donation of blood. *(HP)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society recognizes the importance of soliciting and supporting volunteer blood donations, and the especially critical need for volunteer donations during times of predicted shortages.

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

CHILDREN AND YOUTH *(Please also See Policy Under Environmental/Occupational Health, Pesticides, and Hospitals)*

Adverse Childhood Experiences

The MMS will advocate for policies at the state and federal levels that promote evidence-based strategies to understand, prevent, and mitigate long term harms of adverse childhood experiences (ACEs). *(D)*

MMS House of Delegates, 12/4/21

The MMS affirms that adverse childhood experiences (ACEs) are a public health problem that compound racial disparities in health outcomes. *(HP)*

MMS House of Delegates, 12/5/20

Breastfeeding

The Massachusetts Medical Society affirms that exclusive breastfeeding for the first six months of life is preferred, consistent with the policies of the American College of Obstetricians and Gynecologists, American Academy of Family Physicians, and the American Academy of Pediatrics. *(HP)*

The MMS supports efforts to improve education of physicians regarding appropriate management of breastfeeding, including patient counseling regarding the risks of not breastfeeding, management of common breastfeeding problems, and medication safety for the nursing mother-infant dyad. *(HP)*

The MMS will call upon hospitals to adopt evidence-based policies that have been shown to improve breastfeeding initiation and duration and to reduce the racial and ethnic disparities in these outcomes. *(D)*

The MMS will call upon both public and private insurers to include lactation support as a part of their standard, reimbursable neonatal-care service to include continued and comprehensive support throughout postpartum period. *(D)*

The MMS supports the right of a mother to nurse in public without harassment and encourages breastfeeding-friendly workplaces across the employment spectrum and consistent with state and federal regulations. *(HP)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Bullying
The Massachusetts Medical Society will develop and make available training for health care providers about bullying, cyberbullying, and other forms of harassment. Topics will include the spectrum of bullying behaviors, definitions, risk factors, health effects, techniques for inquiry and identification, intervention and response, and empowerment of those victimized to seek help from a trusted person or organization. All training will emphasize the employment of a trauma-informed and culturally responsive approach, paying particular attention to the needs of individuals who belong to vulnerable and marginalized groups, including but not limited to ethnic and racial minorities, religious minorities, as well as lesbian, gay, bisexual, transgender, questioning persons, and other gender and sexual minorities. *(D)*

MMS House of Delegates, 12/4/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Child-Resistant Packaging *(Please See Additional Policy under Tobacco/Smoking & Prescription and Non-prescription Drugs)*
The MMS will advocate to the American Medical Association and state and federal authorities for laws that would protect children from poisoning by detergent packet products by requiring that these products meet child-resistant packaging requirements and that these products are manufactured to be less attractive to children in color and in design and to include culturally appropriate warning labels in multiple languages. *(D)*

MMS House of Delegates, 12/5/15
(Advocacy to AMA Completed, Reported 12/3/16)
(Amended and Reaffirmed MMS House of Delegates, 5/21/22)

Differences in Sex Development (DSD)/Intersex
The MMS supports optimal management of Differences in Sex Development/Intersex through individualized, multidisciplinary care that (1) seeks to foster the well-being of the child and of the adult the child will become; (2) respects the rights of the patient to participate in decisions and, except when life-threatening circumstances require emergency intervention, defers medical or surgical intervention until the child is able to participate in decision making; and (3) provides psychosocial support to promote patient and family well-being. *(HP)*

MMS House of Delegates, 12/7/19

The MMS will promote the education of providers, parents, patients, and multidisciplinary teams based on the most current evidence concerning the care for individuals born with differences in sex development/intersex. *(D)*

MMS House of Delegates, 12/1/18

Early Education/Childcare
The MMS supports that equitable and universal access to high-quality child care and early education is necessary for the health and well-being of children and their caregivers. *(HP)*

The MMS will advocate for increased public funding for access to early childhood learning and care. *(D)*

The MMS will collaborate with hospitals and educational institutions to identify best practices and incentives to support additional early education and care benefits for employees, students, and trainees. *(D)*

MMS House of Delegates, 5/13/23

Epinephrine Supply
The MMS supports schools using their own emergency supply of epinephrine auto-injectors instead of requiring parents to purchase individually labeled epinephrine auto-injectors for each child and that each student and employee who has life-threatening allergies be required to provide their designated school with an individualized health care plan. *(HP)*

MMS House of Delegates, 12/3/16
(Items 2 and 3 of Original Auto-Sunset: Time-Limited Directives Completed, MMS House of Delegates 12/2/17)
(Reaffirmed for 1 Year Pending Review at A-24)

Family Leave
The MMS supports family leave with job protection and pay for parents/guardians or primary caregivers to care for newborns and infants. *(HP)*

MMS House of Delegates, 12/2/17
(Items 2-3 of Original Auto-Sunset: Time-Limited Directive Completed MMS House of Delegates, 12/2/18)

Guidelines for Sexual Education in Schools
The MMS supports sexual health education that:

a. Is comprehensive, medically accurate, culturally and religiously aware, and age appropriate; and
b. Promotes a perception of sexuality that is free from shame, blame, and stigma; and
c. Prepares individuals to make healthy sexual decisions; and
d. Includes essential concepts and issues such as:
    i. Sexual orientation and gender identity; and
    ii. Power dynamics inherent in sexual relationships, especially as related to age, gender, and substance use; and
    iii. Sexual health and access to sexual and reproductive health care; and
    iv. Intimate partner violence and sexual exploitation; and
    v. Relationships based on mutual respect, communication, and personal responsibility; and
    vi. Risks for HIV and other sexually transmitted infections and unplanned pregnancy; and
    vii. The benefits and risks of barrier methods (including condoms) and other contraceptive methods

(HP)

The MMS will advocate that schools receiving public funding be required to offer age appropriate comprehensive evidence-based sexual health education that:

e. Is based on rigorous, peer-reviewed science; and
f. Incorporates sexual violence prevention including comprehensive discussion on consent and the relationship of substance use to sexual violence; and
g. Shows promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted infections and for becoming pregnant; and
h. Includes an integrated strategy for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; and
i. Utilizes classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of sexual and gender minority youth; and
j. Appropriately and comprehensively address the sexual behavior of all people, inclusive of sexual and gender minorities; and
k. Includes ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; and
l. Is part of an overall health education program; and
m. Includes culturally competent materials that are language-appropriate for Limited English Proficiency (LEP) pupils without sacrificing comprehensiveness.

(D)

MMS House of Delegates, 12/1/18

Literacy Skills/Reach Out and Read Literacy Program
The MMS affirms that early exposure to books and literacy-rich environments has a positive effect on language development and literacy skills, which may reduce health care disparities. *(HP)*

MMS House of Delegates, 4/29/17
(Item 2 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 4/28/18)

Maltreatment and Neglect
The Massachusetts Medical Society will continue to support initiatives to increase physicians', other health workers', and the public's knowledge of child maltreatment to improve education and training methods for the prevention, diagnosis, and treatment of child maltreatment; to promote development of evidence-based programs that continue to advance medical knowledge and competence in the control of this public health problem; and engage in collaborative work with professionals, especially in fields such as child welfare, law, social work, psychology, education, and religion in the management of child maltreatment. *(HP)*

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society, in cooperation with the American Medical Association, various medical specialty societies, and other concerned health organizations, will take immediate initiatives: in increasing physicians', other health workers', and the public's awareness of the nature and extent of the child maltreatment problem; in improving education and training in the use of existing resources and methods for the prevention, diagnosis, and treatment of child maltreatment; in promoting the development of evidence-based and/or innovative programs to advance medical knowledge and competence in the control of this significant health problem; and in encouraging physicians to work with concerned community agencies and as essential components of child protection teams drawn from such fields as law, social work, psychology, and education and religion. *(D)*

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

Safe Infant Sleep
The MMS supports policy adapted from the American Academy of Pediatrics (AAP) policy:

Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SIDS. *(HP)*
MMS House of Delegates, 4/29/17

The MMS adopt the following excerpted guidelines of the Safe Infant Sleeping Environment Guidelines adapted from the American Academy of Pediatrics and the Centers for Disease Control, which read as follows:

- Avoid commercial devices marketed to reduce the risk of SIDS. These devices include wedges, positioners, special mattresses, and special sleep surfaces. There is no evidence that these devices reduce the risk of SIDS or suffocation or that they are safe.
- Media and manufacturers should follow safe-sleep guidelines in their messaging and advertising.

(HP)

MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

Sugar Intake/Beverages
The MMS supports, as part of a healthy approach to childhood nutrition, limiting children's intake of sugar-sweetened beverages and overall added sugar. *(HP)*

MMS House of Delegates, 12/3/16
Reaffirmed MMS House of Delegates, 5/13/23

The MMS will advocate in favor of legislation that establishes state and local excise taxes on sugar-sweetened beverages and encourage the application of the resulting revenues toward programs that support food security and improve access to healthy foods. (*D*)

MMS House of Delegates, 5/4/19

Mental Health and Substance Use
The Massachusetts Medical Society will advocate for primary care practitioners to perform preventive care including careful history, validated screening, and relevant examination for mental health and substance use during visits for adolescents and adults. *(D)*

The Massachusetts Medical Society supports integration of mental health, behavioral health, and substance use treatment into the primary care setting. The MMS supports the elimination of obstacles for payment of these services. *(HP)*

The Massachusetts Medical Society will advocate for counselors within the school system to assist with access for all children, adolescents, and their families and in the community for mental health and substance use counseling. *(D)*

MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Mindfulness Training
The Massachusetts Medical Society will support its members and other health care providers in educating patients and the public in mindfulness-based stress reduction. *(D)*

The Massachusetts Medical Society will encourage education in Massachusetts schools on mindfulness. *(D)*

MMS House of Delegates, 5/7/16
Amended and Reaffirmed, MMS House of Delegates, 5/13/23

Pediatric Screening Tests
The Massachusetts Medical Society recommends that third party payors henceforth provide payment for reasonable periodic check-ups and screening tests in the pediatric and adolescent age group up to age 21.

MMS Council, 2/13/80
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

Perinatal Quality Collaborative
The Massachusetts Medical Society will advocate for legislation to provide annual funding for the Massachusetts Perinatal Quality Collaborative. *(D)*

MMS House of Delegates, 12/7/13
Reaffirmed MMS House of Delegates, 12/5/20

Physical Education
The Massachusetts Medical Society reaffirms its support of continuing physical education and athletic programs in school as essential to the development and maintenance of good physical and mental health of school age children.

MMS Council, 2/11/81
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Religious Exemptions
The Massachusetts Medical Society (MMS) opposes state and federal legislative initiatives that would permit parents to prevent medical examination and medical treatment of their minor children on the basis of religion during a declared public health emergency. *(HP)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

School Start Times
The MMS affirms that a later start time to the school day (no earlier than 8:30 a.m.) for both middle school and high school adolescents is a beneficial change to the overall health and wellbeing of the students. *(HP)*

MMS House of Delegates, 12/5/15
(Item 2 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates 12/3/16)
Reaffirmed MMS House of Delegates, 5/13/23
(Item 3 of Original: Sunset: MMS House of Delegates, 5/13/23)

Special Health Care Needs
The Massachusetts Medical Society (MMS) agrees with the definition of a medical home as care that is accessible, comprehensive, continuous, coordinated, family-centered, compassionate, culturally-competent, and in which the primary care physician shares responsibility for the patient's health and well-being with other participants involved in providing care. *(HP)*

The MMS supports the concept that children with special health care needs should receive care that is accessible, comprehensive, continuous, coordinated, family-centered, compassionate, culturally-competent, and in which the primary care physician shares responsibility. *(HP)*

The MMS encourage both primary and specialty care physicians involved in caring for children with special health care needs to become familiar with the medical home concept and to work within their practices and their specialty societies to incorporate this concept. *(HP)*

MMS House of Delegates, 11/8/03
Reaffirmed (and Items 1 and 2 Amended and Reaffirmed) MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

CIVIL AND HUMAN RIGHTS

Social and Financial Services for Asylum Seekers, Recent Immigrants, Refugees
The MMS supports expedient state level onboarding for social and financial services for asylum seekers, recent immigrants, and refugees. *(HP)*

(Approved MMS Board of Trustees, 9/20/23)
Accepted MMS House of Delegates, 12/9/23

Equitable Health Care Regardless of Immigration Status
The Massachusetts Medical Society adopt the following adapted from American Medical Association policies:

a. The Massachusetts Medical Society recognizes the negative health consequences of the detention of families seeking safe haven. *(HP)*

b. The Massachusetts Medical Society opposes family immigration detention, due to the negative health consequences of detention. *(HP)*

c. The Massachusetts Medical Society opposes the separation of parents from their children who are detained while seeking safe haven. *(HP)*

d. The Massachusetts Medical Society will advocate for safe access to health care for immigrants and refugees in the Commonwealth regardless of immigration status. *(D)*

e. The Massachusetts Medical Society:
- Advocate for and support legislative efforts to designate healthcare facilities as sensitive locations by law *(D)*
- Work with appropriate stakeholders to educate medical providers on the rights of undocumented patients while receiving medical care, and the designation of health care facilities as sensitive locations where US immigration enforcement actions should not occur *(D)*
- Encourage health care facilities to clearly demonstrate and promote their status as sensitive locations *(D)*

- Oppose the presence of immigration enforcement agents at health care facilities *(HP)*

f. The Massachusetts Medical Society:

- Encourage appropriate stakeholders to study the impact of mandated immigration reporting laws on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care *(D)*
- Work with community-based organizations and related stakeholders to study and mitigate the implications of mandated immigration reporting laws, so that immigrants can continue to receive necessary protective services without fear of consequences to their immigration status *(D)*

The Massachusetts Medical Society advocate for legislative/regulatory changes that will protect the civil rights, safety, and well-being of all patients by drawing a clear line between immigration enforcement and health care. *(D)*

MMS House of Delegates, 12/1/18

Food and Cash Assistance Benefits/Legally Present Immigrants

That the MMS supports the provision of state-funded basic needs benefits, including nutrition and cash assistance benefits, to immigrants who are legally present in the United States but ineligible for federally funded basic needs benefits. *(HP)*

That the MMS will advocate for the provision of state-funded basic needs benefits, including nutrition and cash assistance benefits, to immigrants who are legally present in the United States but ineligible for federally funded basic needs benefits. *(D)*

MMS House of Delegates, 5/13/23

Military/Medical Policies Affecting Transgender Individuals *(Please See Additional Policy under Public Health)*

The Massachusetts Medical Society affirms that there is no medically valid reason for the U.S. military to exclude transgender individuals from service or to treat them according to medical standards that differ from those that apply to non-transgender personnel. *(HP)*

MMS House of Delegates, 5/2/15
(Item 2 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/3/15)
Reaffirmed MMS House of Delegates, 5/21/22

Nondiscrimination *(Please See Additional Policy under Public Health)*

The Massachusetts Medical Society strongly condemns all governments that enact laws criminalizing homosexuality or homosexual behavior. *(HP)*

The Massachusetts Medical Society strongly supports the rights of individuals to health, happiness, and liberty regardless of sexual orientation, gender identity, or nationality, and urges all governments to recognize these rights. *(HP)*

MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The MMS reaffirms its commitment to working for the best possible health care for every patient in the Commonwealth regardless of personal demographics, such as racial identification, national or ethnic origin, sexual orientation, sex, gender identity, religious affiliation, disability, immigration status, or economic status. *(HP)*

MMS House of Delegates, 12/3/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The MMS will work to ensure that no health carrier or its designee may adopt or implement a benefit that discriminates on the basis of health status, race, ethnicity, national origin, language, religion, age, sex, gender identity, sexual orientation, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. *(D)*

The MMS will work to see that appropriate action is taken by state regulators when discrimination may exist in benefit designs. *(D)*

The MMS will support improvements to the essential health benefits benchmark plan selection process, to ensure limits and exclusions do not impede access to health care and coverage. *(D)*

The MMS will encourage regulators to develop policy to prohibit essential health benefits substitutions that do not exist in Massachusetts's benchmark plan and the selective use of exclusions of arbitrary limits that prevent high-cost claims or that encourage high-cost enrollees to drop coverage. *(D)*

The MMS will encourage regulators to review current plans for discriminatory exclusions and submit any specific incidents of discrimination through an administrative complaint to the Office for Civil Rights. *(D)*

MMS House of Delegates, 12/3/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society will advocate for the continued training and practice of medical students, residents, and fellows in Massachusetts who are Deferred Action for Childhood Arrivals recipients. *(D)*

MMS House of Delegates, 12/3/16
(Item 1 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 12/2/17)
*Amended and Reaffirmed MMS House of Delegates, 5/13/23 *just added word "will")*

The Massachusetts Medical Society encourages the U.S. government to offer asylum to individuals that need to leave their home country for fear of discrimination based on sexual orientation gender or gender identity, and supports access for these individuals to U.S.-based agencies that can provide assistance with health needs, social adaptation, language training, and enhancing work-related skills. *(D)*

MMS House of Delegates, 5/2/15
(Amended and Reaffirmed MMS House of Delegates, 5/21/22)

The MMS will continue to communicate with its members urging them to serve the common interest of physicians and patients alike, regardless of their gender identity or expression, sexual orientation, race, ethnicity, disability, language, creed, or religious belief(s).

MMS House of Delegates, 11/17/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/22/22

The Massachusetts Medical Society (MMS) will continue to strive for universal access to health care and nondiscrimination in health care settings for all people. *(HP)*

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Nondiscrimination Statement

The Massachusetts Medical Society will make available on its website and provide to new members a sample non-discrimination statement that is suitable for physicians to frame and display in their offices. *(D)*

MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

Torture

The Massachusetts Medical Society (MMS) asserts that physicians should not be coerced or participate in, or otherwise assist or facilitate, the commission of torture of any person. *(HP)*

Physicians who have firsthand knowledge that torture has occurred, is occurring, or has been planned have a duty to promptly inform person or persons in a position to take corrective action. *(HP)*

Physicians providing medical care to individual detainees owe their primary obligation to the well-being of their patients and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military, governmental or civilian agencies; nor should any part of the medical records of any patient or information derived from the treatment relationship be disclosed to persons conducting interrogation of the detainee. *(HP)*

Physicians should not participate in or assist in any coercive interrogation including degradation, threats, isolation, intimidation, humiliation, sensory deprivation or excessive stimulation, sleep deprivation, exploitation of phobias, or intentional infliction of physical pain.
(HP)

MMS House of Delegates, 5/12/06
Item 4: Amended and Reaffirmed MMS House of Delegates, 5/11/13
Items 1-3: Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Transgender Individual's/Restroom of Choice
The MMS acknowledges the psychological, emotional, and physical harm to transgender individuals inherent in obligating the use of a public restroom inconsistent with their gender identity. *(HP)*

The MMS supports transgender individuals' use of public restrooms in accordance with their gender identity. *(HP)*
MMS House of Delegates, 4/29/17
(Item 3 or Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 4/28/18)

COMMUNICATION

Health Insurance Companies
The Massachusetts Medical Society file legislation prohibiting representatives of health insurance companies from initiating communications with patients and their families regarding treatment options and code status. *(D)*
MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

EMERGENCY MEDICAL SERVICES

CPR Programs/Public Access Defibrillation/Bleeding Control
The MMS will advocate at a statewide level that CPR training be required as a condition of graduation for all high schools in the Commonwealth. *(D)*

MMS House of Delegates, 4/29/17

The Massachusetts Medical Society (MMS) will advocate for the availability of accessible automated external defibrillators (AEDs) and severe bleeding kits that include tourniquets in schools, colleges, and other areas experiencing sustained or periodic high-concentrated populations. *(HP)*

The MMS will work with school districts and community agencies, including the American Heart Association, to ensure that a rapid emergency response system that includes automated external defibrillators, severe bleeding kits that include tourniquets, and cardiopulmonary resuscitation-trained personnel is in place at school and college sporting events. *(D)*

The Massachusetts Medical Society will promote widespread population awareness of the "Stop the Bleed" initiative to control severe hemorrhage in disaster and trauma events. *(D)*

The Massachusetts Medical Society will coordinate and collaborate with appropriate partners to promote the training of physicians, first-responders, and the lay public in severe hemorrhage control (including the proper use of tourniquets). *(D)*

The Massachusetts Medical Society will advocate for the training of physicians as instructors in severe hemorrhage control (including the proper use of tourniquets), such that they might promote community education of bleeding control. *(D)*

The Massachusetts Medical Society will advocate for severe hemorrhage control training and deployment of severe bleeding kits that include tourniquets to all first responders such as police officers and firefighters. *(D)*
MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates, 5/7/16
(Amended MMS Board of Trustees, 10/11/17)
Accepted MMS House of Delegates, 12/2/17

The Massachusetts Medical Society supports state legislation that increases CPR training for high school students and work collectively with the American Heart Association, the American Stroke Association, and other entities in an ongoing effort to support this legislation to benefit the citizens of Massachusetts. *(D)*

MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society (MMS) endorses and recommends certification of high school students in Basic Cardiopulmonary Resuscitation, Automated External Defibrillation use, and first aid training including bleeding control. *(HP)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

Emergency Room Overcrowding
The Massachusetts Medical Society (MMS) formally acknowledges that the boarding of patients in emergency departments is contrary to the delivery of quality care. *(HP)*

The MMS formally recognizes that the solution to the crowding in emergency departments may be multifactorial and may include facilitating outflow of patients from the emergency department, improving throughput in the emergency department and exploring alternatives to address inflow without restrictive barriers to access. *(HP)*

The MMS supports policies that eliminate emergency department boarding of patients. *(HP)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society (MMS) recognizes the importance of emergency department overcrowding as a significant barrier to health care access and a potential hazard to patient safety. *(HP)*

The MMS supports efforts to reduce emergency department overcrowding and eliminate the boarding of patients awaiting hospital admission in the emergency department. *(HP)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/14/14
Reaffirmed MMS House of Delegates, 5/8/21

ENVIRONMENTAL HEALTH

Air Quality
The MMS will urge action by state legislative and regulatory entities as well as industry to improve ambient air quality to a maximum of the 25 µg/m3 24-hour standard recommended by the AMA and an annual standard between 8-10 µg/m3 as recommended by the Independent Particulate Matter Review Panel; and pending that change, to urge enforcement of current standards, in order to promote and protect the health of vulnerable populations in Massachusetts; and, be it further *(D)*

The MMS will advocate at the AMA for stronger federal particulate matter air quality standards and improved enforcement that will better protect the public's health. *(D)*

MMS House of Delegates, 12/5/20

The MMS recognizes the association between the use of gas stoves, indoor nitrogen dioxide levels, and asthma. *(HP)*

MMS House of Delegates, 12/7/19
(Item 2 of Original: Auto-Sunset, Time-Limited Directive Completed: MMS House of Delegates, 12/5/20)

The MMS will advocate to the state that EPA indoor air quality standards in primary and secondary schools be enforced. *(D)*

The MMS will work with the appropriate entities, including local health departments and the MA Department of Environmental Protection, to promote awareness of indoor air quality issues in primary and secondary schools. *(D)*

MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society supports minimization of brush burning adjacent to smoke sensitive sites such as schools, hospitals and long-term care facilities. *(HP)*

The Massachusetts Medical Society encourages consumer awareness of nonburning alternatives for the disposal of residential brush and green waste. *(HP)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society (MMS) recognizes the importance of promoting health industry practices that minimize harm to public health and the environment, without compromising patient care. *(HP)*

MMS House of Delegates, 5/31/02
Item 2 of Original: Amended and Reaffirmed MMS House of Delegates, 5/8/09
Item 1 of Original: Reaffirmed MMS House of Delegates 5/8/16
(Item 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society (MMS) acknowledges that medical waste incineration results in pollution with the risk of hazardous effects on human health. *(HP)*

The MMS will request that medical facilities eliminate nonessential incineration of medical waste and phase out PVC plastic and mercury product usage to decrease environmental pollution from health care waste. *(D)*

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
(Item 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society (MMS) advocates for workplaces that are free of environmental tobacco smoke for all workers.*(HP)*

The MMS encourages the enforcement of current laws, rules, and regulations related to air quality in the workplace. *(HP)*

The MMS appeals to the Commonwealth of Massachusetts to enforce laws related to air quality in the workplace. *(HP)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Biodiversity

The Massachusetts Medical Society (MMS) recognizes the importance of the protection of biodiversity and its relationship to human health, especially in terms of the development of drugs and biologicals that are derived from plants, animals, and other elements of the natural world and used to treat disease. *(HP)*

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Biomass Plants
The Massachusetts Medical Society (MMS) urges federal, state, and local government to adopt policies that scrutinize the approval, permitting, and construction of biomass plants, and instead promote public health, energy efficiency and conservation and near zero-pollutant emissions and other renewable energy technologies. *(D)*

MMS House of Delegates, 12/5/09
Item 1 of Original:Amended and Reaffirmed MMS House of Delegates, 5/7/16
Items 2-4 of Original :Sunset MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Chemical/Environmental Exposures
The MMS recognizes the inextricable link between environmental health, animal health, and human health, and the importance of scientific research in informing policies that protect human health from environmental toxins. *(HP)*

The MMS will initiate a public health campaign to promote public awareness of the potential sources of Pollutants and toxins in the environment and their impact on human health. *(D)*

The MMS will advocate for policies, regulations, and legislation that protect and promote environmental and human health and that are aligned with MMS strategic and public health priorities. *(D)*
MMS House of Delegates, 4/29/17

The MMS recommends that physicians, as part of routine clinical practice, take an environmental history of patients to understand whether they may be exposed to potential toxic exposures in the home, workplace, or environment. *(HP)*

The MMS finds that there is currently insufficient science about the causes of ─ or treatments for ─ the constellation of symptoms referred to as "chemical sensitivity" (also known as "multiple chemical sensitivity" or "idiopathic environmental illness") to support any treatment modalities for these symptoms. *(HP)*

That, if and when there is a body of peer-reviewed, evidence-based, scientific literature, that more clearly defines the syndrome known as multiple chemical sensitivity, the sequelae of acute exposures, and other related phenomena, that subsequent continuing medical education that the MMS may sponsor be based on scientific investigation and confirmation. *(HP)*
MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Climate Change
The MMS will advocate for effective Massachusetts state policies and legislation addressing climate change mitigation and adaptation. *(D)*
MMS House of Delegates, 5/13/23

The Massachusetts Medical Society adopts the following adapted from American Medical Association policy:

a) The MMS concurs with the findings of the Intergovernmental Panel on Climate Change's fifth assessment report that "human influence on the climate system is clear, and recent anthropogenic emissions of greenhouse gases are the highest in history"; that "recent climate changes have had widespread impacts on human and natural systems"; that "climate change will amplify existing risks and create new risks for natural and human systems"; and "that risks are unevenly distributed and are generally greater for disadvantaged people and communities in countries at all levels of development." *(HP)*

b) The MMS recognizes the importance of physician involvement in policymaking at the state, national, and global levels and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect human health. *(HP)*

c) The MMS encourages physicians to consider and promote environmentally responsible policies and practices in the health care setting. *(HP)*

MMS House of Delegates, 12/3/16
(Item 2 of Original Auto Sunset: Time-Specific Directive Completed MMS House of Delegates, 12/2/17)
Reaffirmed MMS House of Delegates, 5/13/23
(Item 3 of Original Sunset: MMS House of Delegates, 5/13/23)

Correctional Facilities Temperature
The MMS supports the creation and implementation of a maximum safe year-round temperature in all areas of correctional facilities where incarcerated people are being held. *(HP)*

MMS House of Delegates, 12/9/23

Fluoridation
The Massachusetts Medical Society will promote the fluoridation of community water supplies in Massachusetts through its educational and legislative efforts. *(D)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society endorses the goal of achieving 79% of Massachusetts citizens living in communities with community water fluoridation in line with national goals. *(HP)*

The Massachusetts Medical Society will coordinate its relevant oral health legislative and educational activities with respect to community water fluoridation with the Massachusetts Dental Society. *(D)*

MMS House of Delegates, 12/5/20
(Item 3 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/4/21)

Fossil Fuels
The MMS recognizes the health, safety, and climate risks of fossil fuel-derived hydrogen. *(HP)*
(Approved MMS Board of Trustees 1/12/22)
(Accepted MMS House of Delegates, 5/21/22)
(Items 2-3 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates 12/10/22)

The MMS adopts the following, partially adapted from AMA policy:

The MMS, the MMS and Alliance Foundation, and any affiliated corporations or subsidiaries should work in a timely, incremental, and fiscally responsible manner, to the extent allowed by their legal and fiduciary duties, to end all financial investments or relationships (divestment) with companies that generate the majority of their income from the exploration for, production of, transportation of, or sale of fossil fuels. *(D)*

The MMS should choose for its commercial relationships, when fiscally responsible, vendors, suppliers, and corporations that have demonstrated environmental sustainability practices that seek to minimize their fossil fuels consumption. *(D)*

The MMS will support efforts of physicians and other health professional associations to proceed with divestment, including to create policy analyses, support continuing medical education, and to inform our patients, the public, legislators, and government policy makers. *(D)*

The MMS shall report every two years to the BOT and the HOD, for a period of six years, on progress toward divestment of fossil fuel investments. *(D)*

The MMS shall report every two years to the BOT and the HOD, for a period of six years, on the voting decisions made in proxy voting services of the Institutional Shareholders, Services, Inc. (ISS) using the customized MMS, US, and International guidelines to vote the shares held in the MMS Portfolio. *(D)*

MMS House of Delegates, 12/1/18
(Original Items 4-5 Auto-Sunset; Time-Specific Directives Completed MMS House of Delegates 12/9/23)

That in order to promote public health and safety for current and future generations, the MMS will encourage education about the health impacts of fossil fuel usage and advocacy to reduce the use of fossil fuels and increase healthier and safer energy sources. (D)

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15
(Amended and Reaffirmed MMS House of Delegates, 5/21/22)

Gas-Powered Leaf Blowers/Noise and Pollution

The MMS supports governmental/environmental agencies and/or relevant stakeholders exploring the feasibility of an evidence-based metric beyond purely A-weighted noise to more accurately capture lower-frequencies in the public soundscape. *(HP)*

MMS House of Delegates, 12/1/18

The MMS adopts the following adapted from American Medical Association policies:

The MMS recognizes noise pollution as a public health hazard, with respect to hearing loss, and supports initiatives to increase awareness of the health risks of loud noise exposure. *(HP)*

The MMS urges the maximum feasible reduction of all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants. *(HP)*

The MMS acknowledges the increased risk of adverse health consequences to workers and general public from gas-powered leaf blowers including hearing loss and cardiopulmonary disease. *(HP)*

MMS House of Delegates, 4/29/17

Heat Injury/Illness

The MMS will advocate for development of a Massachusetts heat standard to protect outdoor and indoor workers from excessive heat. *(D)*

The MMS will advocate for legislation and policies that foster development of Massachusetts heat injury and heat-related illness prevention programs. *(D)*

The MMS will work with community stakeholders and organizations to promote existing educational materials in multiple languages regarding heat injury and heat-related illness prevention to protect the Commonwealth's most vulnerable workers (including those from communities of color/historically marginalized communities). *(D)*

MMS House of Delegates, 12/4/21

Mercury

The Massachusetts Medical Society (MMS) encourages physicians to inform patients about the health risks of mercury in fish. *(HP)*

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society (MMS) encourages physicians and medical facilities to continue the process of completely phasing out the use of mercury-containing medical instruments from medical care facilities. *(HP)*

The MMS encourages responsible recycling of mercury-containing fluorescent bulbs and other mercury-containing products. *(HP)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Natural Gas

The MMS will advocate for a thorough safety/evacuation and climate assessment of the Weymouth natural gas, as promised by the Commonwealth. *(D)*

The MMS will advocate for the placement of permanent air quality monitors at the Weymouth natural gas

compressor to monitor for benzene, formaldehyde, and particulate matter, as promised by the Commonwealth. *(D)*

The MMS will advocate for a legislative review of the approval process of the Weymouth natural gas compressor and why the health impact assessment did not include a safety evacuation plan, an assessment of the project's climate impact, or consideration of the important health risks from emissions to the children who live in close proximity to the compressor. *(D)*

That if the Weymouth natural gas compressor project continues to go forward despite manifold serious health hazards to vulnerable populations, then the MMS will advocate for a prospective study of health outcomes in this population. *(D)*

MMS House of Delegates, 12/5/20

The MMS adopts the following adapted from AMA policy:
That the MMS recognizes the potential impact on human health associated with natural gas infrastructure. *(HP)*

The MMS will advocate to appropriate agencies and the Massachusetts state legislature to require ongoing independent Comprehensive Health Impact Assessments to assess the human health risks of all existing and proposed new or expanded natural gas infrastructure in Massachusetts. *(D)*

MMS House of Delegates, 4/29/17

Neonicotinoids
The MMS is concerned about harmful effects of neonicotinoids on public health. *(HP)*

The MMS advocates for research and development of less hazardous alternatives to neonicotinoids. *(HP)*

MMS House of Delegates, 4/28/18

Nuclear Energy
The MMS will advocate to Massachusetts legislators and/or regulatory entities to fund scientific studies to adequately evaluate the health effects of decommissioning the Pilgrim Nuclear Power Station on workers, residents, and the environment that might include evaluation of radioactive releases, collection of biometric data, and placement of appropriate radiation monitors prior to proceeding. *(D)*

The MMS encourages the AMA to advocate for strict limitations of aerosol, soil, and/or water radionuclide releases in the decommissioning of US nuclear power plants in order to protect health, particularly that of local vulnerable populations. *(D)*

MMS House of Delegates, 12/9/23

The Massachusetts Medical Society supports the position that thyroid-blocking agents approved by the Food and Drug Administration should be provided to all Massachusetts cities and towns in order that their residents have access to medical protection against injury from radioiodine. *(HP)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Per- and Polyfluoroalkyl Substances (PFAS)
The MMS will work to educate Massachusetts clinicians regarding sources of exposure to per- and polyfluoroalkyl substances (PFAS), their health effects and potential toxicities, and mitigation and prevention strategies by increasing awareness of existing educational resources available to Massachusetts clinicians, doctors' offices and medical facilities. *(D)*

The MMS will advocate to the Massachusetts Department of Public Health, to the AMA and to primary care specialty organizations to improve physician and public education around the adverse health effects of PFAS and potential mitigation and prevention efforts. *(D)*

MMS House of Delegates, 12/10/22
(Items 2-5 of Original: Auto-Sunset; Time-Limited Directives Completed MMS House of Delegates, 12/9/23)
(Item 6 of Original/AMA portion completed MMS House of Delegates, 12/9/23)

Pesticides
The MMS recognizes that there are associations between early life exposure to pesticides and health sequelae in children. *(HP)*

The MMS will educate the public about the potential health effects of pesticides. *(D)*

The MMS will advocate for utilization of non-toxic alternatives to pesticides where possible. *(D)*

The MMS will advocate to decrease children's exposure to pesticides particularly near schools and childcare centers. *(D)*

MMS House of Delegates, 5/21/22

Radio Frequency Radiation
The Massachusetts Medical Society supports continuing research, including quality epidemiologic studies, by appropriate agencies and entities to produce evidence-based data on the effect(s) of radio frequency radiation on human health. If indicated, study findings should be used to revise and update public health standards for safe limits of human exposure to radio frequency radiation. *(HP)*

MMS House of Delegates, 12/4/21

Water Filtration
The Massachusetts Medical Society (MMS) strongly supports aggressive watershed protection throughout the Commonwealth. *(HP)*

The MMS strongly supports accelerated rehabilitation of the water distribution system in the Massachusetts Water Resources Authority (MWRA) service area and in the remainder of the Commonwealth. *(HP)*

The MMS strongly advocates for enhanced monitoring and surveillance systems for contaminants and waterborne disease throughout the Commonwealth. *(HP)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

ETHICS

Billing and Collection Practices
Principles Related to Billing and Collection Practices for the Reimbursement of Professional Services.

1. Physician Participation in Development of Billing and Collection Policies. Every physician should have input into the development of their own, their group's or their employer's billing and collections policies because those policies affect the physician's ethical obligation to his or her patients and they impact on the physician/patient relationship.

2. Periodic Review of Billing and Collection Policies. Billing and collection policies should be reviewed periodically in order to assess the impact on patient care and avoid physician/patient conflict over reimbursement for professional services.

3. Physician Review of Accounts Designated for Collection. The decision to send a patient account to collection may have ethical ramifications due to the potentially serious consequences for the patient and the physician/patient relationship. Physicians are encouraged to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (AMA Council on Ethical and Judicial Affairs Opinion 1.3.3 "Interest and Finance Charges"). Employers should accord employed physicians the opportunity to review their patients' accounts prior to such accounts being sent to collection. If physician review of all accounts is impractical, it may be appropriate for physicians to review only those accounts where the patient or patient's representative has communicated with the physician's office about the delinquent bill.

4. Content of Billing and Collection Policies. Billing and collection policies should be reasonable and should not conflict with applicable state and federal law and the physician's ethical duties to his or her patient.

5. Departure from Established Policies. It is ethical for a physician to depart from established billing and collection policies in order to accommodate the particular needs of a patient.

6. Professional Courtesy. Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement and is prohibited in many jurisdictions. (AMA CEJA Opinion 11.3.1 "Fees for Medical Services").

7. Forgiveness or Waiver of Insurance Co-payments. Under the terms of many health insurance policies or programs, patients are made more conscious of the cost of their medical care through co-payments. By imposing co-payments for office visits and other medical services, insurers hope to discourage unnecessary health care. In some cases, financial hardship may deter patients from seeking necessary care if they would be responsible for a co-payment for the care. Physicians commonly forgive or waive co-payments to facilitate patient access to needed medical care. When a co-payment is a barrier to needed care because of financial hardship, physicians should forgive or waive the co-payment.

   Physicians should be aware that forgiveness or waiver of co-payments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of co-payments may constitute fraud under state and federal law. Physicians should ensure that their policies on co-payments are consistent with applicable law and with the requirements of their agreements with insurers. (AMA CEJA Opinion 11.1.4 "Financial Barriers to Health Care Access").

(HP)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 4/28/18

Capital Punishment

The Massachusetts Medical Society adopts the American Medical Association Council on Ethical and Judicial Affairs Opinion E-9.7.3 *Capital Punishment*, adopted in 2016, with the exclusion of the provision of the opinion regarding organ donation by prisoners, to read as follows:

Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

Physician participation in execution is defined as actions that fall into one or more of the following categories:
(a) would directly cause the death of the condemned;
(b) would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; and
(c) could automatically cause an execution to be carried out on a condemned prisoner.

These actions include, but are not limited to:
(d) determining a prisoner's competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker, such as a judge or hearing officer;
(e) treating a condemned prisoner who has been declared incompetent to be executed for the purpose of restoring competence, unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent medical examiner;
(f) prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure;
(g) monitoring vital signs on site or remotely (including monitoring electrocardiograms);
(h) attending or observing an execution as a physician;
(i) rendering of technical advice regarding execution.
And, when the method of execution is lethal injection:
(j) selecting injection sites;
(k) starting intravenous lines as a port for a lethal injection device;
(l) prescribing, preparing, administering, or supervising injection drugs or their doses or types;
(m) inspecting, testing, or maintaining lethal injection devices; and
(n) consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution:
(o) testifying as to the prisoner's medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution;
(p) certifying death, provided that the condemned has been declared dead by another person;
(q) witnessing an execution in a totally nonprofessional capacity;
(r) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity;
(s) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution; (t) providing medical intervention to mitigate suffering when an incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness.

No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.
(HP)

MMS House of Delegates, 11/04/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 4/28/18

Cloning
The Massachusetts Medical Society adopts the following updated policy, set forth in Opinion 4.2.6 of the American Medical Association Code of Ethics, "Cloning for Reproductive Purposes," which reads as follows:

Somatic cell nuclear transfer (SCNT) is the process in which the nucleus of a somatic cell of an organism is transferred into an enucleated oocyte. Cloning for reproduction, that is, the application of SCNT to create a human embryo that shares all of its nuclear genes with the donor of the human somatic cell, has been debated as having possible clinical benefit. It has been suggested that reproductive cloning might be ethically acceptable to assist individuals or couples to reproduce and to create a compatible tissue donor.

Misconceptions often surround proposals for reproductive cloning, including the mistaken notion that one's genotype determines one's individuality and using SCNT to create a human embryo would replicate a person (the donor of the somatic cell).

The possible use of SCNT in reproductive medicine also poses risks of unknown physical harms from the technology itself, including concerns about long-term safety, and the possibility that SCNT will be associated with genetic anomalies or have other unforeseen medical consequences. Reproductive cloning also carries the risk of psychosocial harm, including violations of privacy and autonomy and the possibility of compromising the cloned child's right to an open future by creating enormous pressures to live up to expectations based on the life of the somatic cell donor.

Reproductive cloning may have adverse effects on familial and societal relations and on the gene pool in altering reproductive patterns and the resulting genetic characteristics of a population, including posing harms to future generations if deleterious genetic mutations are introduced. Moreover, reproductive cloning has the potential to be used in a eugenic or discriminatory fashion—practices that are incompatible with the ethical norms of medicine.
In light of the physical risks of SCNT, ongoing moral debate about the status of the human embryo, and concerns about the impact of reproductive cloning on cloned children, families and communities, reproductive cloning is not endorsed by the medical profession or by society.

Should reproductive cloning at some point be introduced into medical practice, physicians must be aware that cloning techniques must not be used without the informed consent of the somatic cell donor, the oocyte donor, and the prospective rearing parent(s), in keeping with ethics guidance for assisted reproduction.

Further, any child produced by reproductive cloning would be entitled to the same rights, freedoms, and protections as every other individual in society, irrespective of the fact that the child's nuclear genes derive from a single individual.

As professionals dedicated to protecting the well-being of patients, physicians should not participate in using SCNT to produce children. Because SCNT technology is not limited to any single country, physicians should help establish international guidelines governing its uses before experimentally proven techniques are introduced into clinical practice. *(HP)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Confidentiality: Medical Student Physical Diagnosis

The Massachusetts Medical Society will support the protection of medical student privacy and confidentiality in the context of physical diagnosis classes by adopting the following principles:

1. Students should be free to decide whether or not to participate as patient models in physical diagnosis classes, with no penalty for refusal to participate as patient models for any reason.
2. If abnormal physical findings are found on a student during a physical diagnosis class, the student should not be used as a model of abnormal findings without their explicit, meaningful, and non-coerced consent.

No information regarding abnormal physical findings encountered on a medical student during a physical diagnosis class should be transmitted to any third party (by instructors or fellow students) without the student's explicit, meaningful, and non-coerced consent.
(HP)

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Confidentiality: Statement of Principles

General Principles

(1) The patient has a fundamental right to privacy and confidentiality in his/her relationship with a physician. It is the physician's responsibility to do his/her best to protect the patient's privacy and confidentiality.

Patient-physician relationships should be governed by mutual trust, respect, courtesy, honesty, and confidentiality.

(2) Privacy and confidentiality are the privileges of the patient, so only he or she may waive them, in a meaningful and non-coerced fashion.

Release of information for a specific purpose such as insurance payment should not require waiver of the total right to privacy and confidentiality.

(3) An individual's rights to privacy and confidentiality should not be compromised. Statutory and regulatory exceptions should be specific and narrowly defined.

(4) Conflict between a patient's right to privacy and a third party's need to know should be resolved in favor of the patient's privacy and confidentiality except where that may result in serious harm to the patient or others.

(5) The development and acceptance of new information technologies should include measures that strengthen, not jeopardize, patient privacy and confidentiality.

(6) Physicians have an ethical responsibility to understand issues of privacy and confidentiality, educate their staffs, and make reasonable efforts to inform their patients of these issues.

Principles Pertaining to Confidentiality of Medical Information in Health Insurance

(1) Physician participation in an insurance plan must not be contingent upon the physician's agreement to release medical records for various insurance company purposes, without meaningful patient consent.

(2) A subscriber's ability to obtain health insurance must not be contingent upon the subscriber's agreement to a broad and indefinite consent for disclosure. A subscriber should not be required to consent to the disclosure of medical information for other adults enrolled in the plan as the subscriber's dependents or family members. The amount of information that an individual must disclose in order to qualify for health insurance benefits and payment must be strictly defined and limited.

(3) Every insurer should formally disclose in writing to each individual adult covered by the health plan the insurer's specific policies and procedures for accessing confidential patient information, including the uses for which medical information is sought and the numbers and functions of persons who have access to it. This written information should be supplied at least annually.

(4) Insurers should limit the scope of medical information to that which is absolutely necessary to complete the particular function, and should not seek to obtain the whole medical record. Information obtained for one purpose should not be used for other purposes.

(5) Only completely disidentified patient information should be used to perform insurance panel credentialing, quality assurance monitoring and routine utilization review.

(6) Each time medical information is sought, the insurer should obtain the individual patient's written consent, which must specify:

a) the precise scope of the information requested, with clinical information limited to what is absolutely necessary to perform the particular function.

b) the specific purpose for which the information is sought.

c) the name of the recipient(s) of the information. If the recipient is an institution, the functions of the persons who will have access to it should be specified.

d) whether the information needed is identified or disidentified information. If disidentified information is appropriate it should be done by the physician's office prior to its release.

e) that the patient has the right to review the information requested prior to any disclosure, whether the information is identified or disidentified.

f) where and how the information will be stored and when it will be destroyed.

g) the identities of any secondary data processing companies that are receiving their medical information.

h) the consequences of withholding or limiting consent, and specific instructions as to the appeal process.

(7) Insurers shall adopt and enforce prohibitions on redisclosure or reuse of medical information for secondary purposes, even within the insurance company or payer itself.

(8) Physicians have the right to remove sensitive information before submitting medical information to the insurer, or to provide a summary of the record. This should include any information pertaining to persons other than the patient.

(9) Patient specific utilization review and eligibility determinations should be performed by a peer reviewer and only the reviewer (not the payer) should have access to the clinical information necessary for review. This information should have the name of the patient and other obvious identifiers removed for the purposes of review.

(10) Any disclosure of information must be traceable for both electronic and paper records.

(11) There is an increased threat to privacy and confidentiality when providers and payers merge. Hence, further protections are necessary to prevent access to medical information for administrative purposes.

(12) There should be enforced time lines for the destruction of medical information. Medical information should not be warehoused by insurance companies.

Principles Pertaining to Information Technology and Electronic Medical Records

(1) Electronic medical records offer an opportunity for dramatic benefits to patients in clinical care, research and the delivery of health care. However, electronic records will not be capable of providing these benefits unless patient privacy and confidentiality are strengthened, not jeopardized, by new policy governing information technologies.
(2) Regarding the electronic record, as with the paper record, the patient has the right to privacy and confidentiality of his/her personally identified medical information.
(3) For any individual or organizations with authorized access to the electronic medical record, the level of access permitted should be specifically identified in advance. Full disclosure of this information to the patient is necessary.
(4) Patient data should be assigned security protections that should be used to control who has access to the information. In addition, mandatory audit trails to determine who had accessed the electronic record should be maintained and made available to the attending physician, and to the patient upon the patient's request.
(5) Physicians should be educated about technologies of security.
(6) In systems of electronic medical records, patients, in consultation with their physicians, should be able to specify what information should not be disseminated.
(7) While offering potential clinical and research benefits, systems designed to encourage data linkage through the mandatory use of unique health identifiers or standard code sets may jeopardize patient privacy and should require patient consent.
(8) Patient-specific information should not be released to data clearinghouses without meaningful notice to and consent of the patient, and assurance of privacy and confidentiality.
(9) Organizations concerned with the development of electronic medical records should be encouraged to pursue research, development and education in matters related to privacy and confidentiality.
(10) Firm, explicit state and federal statutes should regulate access to identified confidential electronic patient data and define punitive measures for negligence and deliberate violation of security measures. (Amended and Reaffirmed, MMS House of Delegates, 5/7/16)

Principles Pertaining to Genetic Information

(1) All genetic testing must be voluntary and done with fully informed consent.

(2) Results of genetic testing should not be disclosed to anyone other than the tested individual, unless the individual gives separate and explicit written consent for each disclosure.

(3) Results of any genetic testing and family history data should be segregated in the patient's medical record and protected from inadvertent disclosure.

(4) Pre- and post-test genetic counseling should include implications of genetic information for patients' biological relatives. At the time patients are considering undergoing genetic testing, physicians should discuss with them whether or not to invite family members to participate in the testing process. Physicians also should identify circumstances under which they would expect patients to notify biological relatives of the availability of information related to risk of disease. In this regard, physicians should make themselves available to assist patients in communicating with relatives to discuss opportunities for counseling and testing, as appropriate.

Physicians who order genetic tests should have adequate knowledge to interpret information for patients. In the absence of adequate expertise in pre-test and post-test counseling, a physician should refer the patient to an appropriate specialist.

Principles Pertaining to Research

(1) Clinical research is essential to the advancement of medicine. Without privacy and confidentiality, patients will not reveal and physicians will not record accurate information necessary for clinical care or research. Therefore, medical information used for research, including public health research, should be disidentified at the source, unless the patient voluntarily and expressly consents to the use of his/her personally identifiable information. An institutional review board that conforms to federal standards may permit the release of limited patient-specific information to the researcher for clinical research purposes.

(2) Whenever personally identifiable medical information is used in research, patient privacy and confidentiality should be protected and the further disclosure of information should be prohibited.

Principles Pertaining to Public Safety

(1) In the interest of public safety, law enforcement officials may access medical records by court order specifying: the particular individual, the specific and limited portion of the medical record requested, that good cause was shown that the public's safety necessitates the access, that there is no other non-confidential source for the information, and that it will be viewed but not retained in the law enforcement file beyond the immediate reason for which it is sought.

Principles Pertaining to Marketing and Commercial Use

(1) Patient medical information, whether identified or disidentified, should not be a commodity in the marketplace, and should not be made available for purchase or sale by any individual or entity.

(2) Even the most general patient information should not be disclosed to vendors or others for marketing purposes without the patient's written informed consent.

(HP)

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 12/3/11
Amended and Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

Ethics and Managed Care
The Massachusetts Medical Society Policy Statement on Ethics and Managed Care states:

Ethics of Financing and Delivery of Health Care
Preamble:

The medical profession has long subscribed to a body of ethical standards. Initially developed for the benefit of the patient, ethical principles must also serve to guide the physician in his or her relationship with colleagues as well as other entities in the health care arena. Several relevant principles adopted by the American Medical Association and the Massachusetts Medical Society remain constant:

- A physician shall be dedicated to providing competent medical services with compassion and respect for human dignity, in a cost-effective manner.
- A physician shall deal honestly with patients and colleagues.
- A physician shall respect the law and also recognize a responsibility to seek changes in those requirements that are contrary to the best interests of the patient.
- A physician shall make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- A physician shall, in the provision of appropriate patient care, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

Changes in the practice environment require physicians to examine their professional relationships even more closely.

As health care has become more complex and costlier, new challenges have emerged. Payment models and incentive mechanisms intended to contain costs and improve quality may create conflicts of interest that work against the goal of providing care that is responsive to the unique needs, values, and preferences of individual patients.

The following principles are offered to reaffirm the primacy of the physician-patient relationship and the standards of conduct between and among colleagues. Further, they provide general recommendations related to physicians' ethical responsibilities to address questions of access to care, for individuals and for populations of patients, in their role as practicing clinicians, as leaders of health care organizations and institutions, and collectively as a profession.

These principles are offered as ethics guidance for physicians and are not intended to establish clinical Practice guidelines or rules of law.

PROFESSIONALISM IN HEALTH CARE SYSTEMS (Adapted from AMA CEJA Opinion 11.2.1)
Containing costs, promoting high-quality care for all patients, and sustaining physician professionalism are Important goals. Models for financing and organizing the delivery of health care services often aim to promote patient safety and to improve quality and efficiency. However, they can also pose ethical challenges for physicians that could undermine the trust essential to patient-physician relationships.

Payment models and financial incentives can create conflicts of interest among patients, health care organizations, and physicians. They can encourage undertreatment and overtreatment, as well as dictate goals that are not individualized for the particular patient.

Structures that influence where and by whom care is delivered — such as accountable care organizations, group practices, health maintenance organizations, and other entities that may emerge in the future — can affect patients' choices, the patient-physician relationship, and physicians' relationships with fellow health care professionals.

Formularies, clinical practice guidelines, and other tools intended to influence decision making may impinge on physicians' exercise of professional judgment and ability to advocate effectively for their patients, depending on how they are designed and implemented.
Physicians in leadership positions within health care organizations should ensure that practices for financing and organizing the delivery of care:

(a) Are transparent.
(b) Reflect input from key stakeholders, including physicians and patients.
(c) Recognize that over reliance on financial incentives may undermine physician professionalism.
(d) Ensure ethically acceptable incentives that:
(i) Are designed in keeping with sound principles and solid scientific evidence. Financial incentives should be based on appropriate comparison groups and cost data and adjusted to reflect complexity, case mix, and other factors that affect physician practice profiles. Practice guidelines, formularies, and other tools should be based on best available evidence and developed in keeping with ethics guidance;
(ii) Are implemented fairly and do not disadvantage identifiable populations of patients or physicians or exacerbate health care disparities;
(iii) Are implemented in conjunction with the infrastructure and resources needed to support high-value care and physician professionalism;
(iv) Mitigate possible conflicts between physicians' financial interests and patient interests by minimizing the financial impact of patient care decisions and the overall financial risk for individual physicians.
(e) Encourage, rather than discourage, physicians (and others) to:
(i) Provide care for patients with difficult to manage medical conditions;
(ii) Practice at their full capacity, but not beyond.
(f) Recognize physicians' primary obligation to their patients by enabling physicians to respond to the unique needs of individual patients and providing avenues for meaningful appeal and advocacy on behalf of patients.
(g) Are routinely monitored to:
(i) Identify and address adverse consequences;
(ii) Identify and encourage dissemination of positive outcomes.

All physicians should:

(h) Hold physician-leaders accountable to meeting conditions for professionalism in health care systems.
(i) Advocate for changes in health care payment and delivery models to promote access to high-quality care for all patients.

PHYSICIAN STEWARDSHIP OF HEALTH CARE RESOURCES (Adapted from AMA CEJA Opinion 11.2.2)
Physicians' primary ethical obligation is to promote the well-being of individual patients. Physicians' have a secondary obligation to promote public health and access to care. Part of this secondary obligation

includes physician awareness of health care resource limitations. It is incumbent upon physicians to consider these limitations when making medical decisions. With this in mind, physicians should:

(a) Base recommendations and decisions on patients' medical needs.
(b) Use scientifically grounded evidence to inform professional decisions when available.
(c) Help patients articulate their health care goals and help patients and their families form realistic expectations about whether a particular intervention is likely to achieve those goals.
(d) Endorse recommendations that offer reasonable likelihood of achieving the patient's health care goals.
(e) Choose the course of action that requires fewer resources when alternative courses of action offer similar likelihood and degree of anticipated benefit compared to anticipated harm for the individual patient but require different levels of resources.
(f) Be transparent about alternatives, including disclosing when resource constraints play a role in decision making.
(g) Participate in efforts to resolve persistent disagreement about whether a costly intervention is worthwhile.

Physicians are in a unique position to affect health care spending. But individual physicians alone cannot and should not be expected to address the systemic challenges of wisely managing health care resources. Medicine as a profession must create conditions for practice that make it feasible for individual physicians to be prudent stewards by:

(h) Encouraging health care administrators and organizations, including insurance companies, to make cost data transparent (including cost accounting methodologies) so that physicians can exercise well-informed stewardship.
(i) Ensuring that physicians have the training they need to be informed about health care costs and how their decisions affect overall health care spending.
(j) Advocating for policy changes, such as medical liability reform, that promote professional judgment and address systemic barriers that impede responsible stewardship.

ALLOCATING LIMITED HEALTH CARE RESOURCES (Adapted from AMA CEJA Opinion 11.1.3)
Physicians' primary ethical obligation is to promote the well-being of their patients. Policies for allocating scarce health care resources may impede physicians' ability to fulfill that obligation.

As professionals dedicated to protecting the interests of their patients, physicians thus have a responsibility to contribute their expertise to developing allocation policies that are fair and safeguard the welfare of patients.

Individually and collectively through the profession, physicians should advocate for policies and procedures that allocate scarce health care resources fairly among patients.

Allocation policies should be based on criteria relating to medical need, including urgency of need, likelihood and anticipated duration of benefit, and change in quality of life and use of lower cost alternatives of equal quality. In limited circumstances, it may be appropriate to take into consideration the amount of resources required for successful treatment. It is not appropriate to base allocation policies on social worth, perceived obstacles to treatment, patient contribution to illness, past use of resources, or other non-medical characteristics.

FINANCIAL BARRIERS TO HEALTH CARE ACCESS (Adapted from AMA CEJA Opinion 11.1.4)
Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means.

In view of this obligation:

(a) Individual physicians should help patients obtain needed care through public or charitable programs when patients cannot do so themselves.

(b) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
(c) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to appropriate health services.
(d) All stakeholders in health care, including physicians, health facilities, health insurers, professional medical societies, and public policymakers must work together to ensure necessary access to appropriate health care for all people.

CONFLICTS OF INTEREST IN PATIENT CARE (AMA CEJA Opinion 11.2.2)
The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients.

Treatment or hospitalization that is willfully excessive or inadequate constitutes unethical practice. Physicians should not provide wasteful and unnecessary treatment that may cause needless expense solely for the physician's financial benefit or for the benefit of a hospital or other health care organization with which the physician is affiliated.

Where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.

CONTRACTS TO DELIVER HEALTH CARE SERVICES (AMA CEJA Opinion 11.2.3)
Physicians have a fundamental ethical obligation to put the welfare of patients ahead of other considerations, including personal financial interests. This obligation requires them to consider carefully the terms and conditions of contracts to deliver health care services before entering into such contracts to ensure that those contracts do not create untenable conflicts of interests.

Ongoing evolution in the health care system continues to bring changes to medicine, including changes in reimbursement mechanisms, models for health care delivery, restrictions on referral and use of services, clinical practice guidelines, and limitations on benefits packages. While these changes may be intended to enhance quality, efficiency, and safety in health care, they may also put at risk physicians' ability to uphold professional ethical standards of informed consent and fidelity to patients and can impede physicians' freedom to exercise independent professional judgment and tailor care to meet the needs of individual patients.

As physicians enter into various differently structured contracts to deliver health care services — with group practices, hospitals, health plans, or other entities — they should be mindful that while many arrangements have the potential to promote desired improvements in care, some arrangements also have the potential to impede patients' interests.

When contracting to provide health care services, physicians should:

(a) Carefully review the terms of proposed contracts or have a representative do so on their behalf to assure themselves that the arrangement:

(i) Minimizes conflict of interest with respect to proposed reimbursement mechanisms, financial or performance incentives, restrictions on care, or other mechanisms intended to influence physicians' treatment recommendations or direct what care patients receive, in keeping with ethics guidance;
(ii) Does not compromise the physician's own financial well-being or ability to provide high-quality care through unrealistic expectations regarding utilization of services or terms that expose the physician to excessive financial risk;
(iii) Allows the physician to appropriately exercise professional judgment;
(iv) Includes a mechanism to address grievances and supports advocacy on behalf of individual patients;
(v) Permits disclosure to patients.

(b) Negotiate modification or removal of any terms that unduly compromise physicians' ability to uphold ethical standards.

TRANSPARENCY IN HEALTH CARE (AMA CEJA Opinion 11.2.4)

Respect for patients' autonomy is a cornerstone of medical ethics. Patients must rely on their physicians to provide information that patients would reasonably want to know to make informed, well-considered decisions about their health care. Thus, physicians have an obligation to inform patients about all appropriate treatment options, the risks and benefits of alternatives, and other information that may be pertinent, including the existence of payment models, financial incentives and formularies, guidelines, or other tools that influence treatment recommendations and care.

Restrictions on disclosure can impede communication between patient and physician and undermine trust, patient choice, and quality of care.

Although health plans and other entities have primary responsibility to inform patient-members about plan provisions that will affect the availability of care, physicians may share in this responsibility.

Individually, physicians should:

(a) Disclose any financial and other factors that could affect the patient's care.
(b) Disclose relevant treatment alternatives, including those that may not be covered under the patient's health plan.
(c) Encourage patients to be aware of the provisions of their health plan.

Collectively, physicians should advocate that health plans with which they contract disclose to patient-members.

(d) Plan provisions that limit care, such as formularies or constraints on referrals.
(e) Plan provisions for obtaining desired care that would otherwise not be provided, such as provision for off-formulary prescribing.
(f) Plan relationships with pharmacy benefit management organizations and other commercial entities that have an interest in physicians' treatment recommendations.

CONSULTATION, REFERRAL, SECOND OPINIONS (AMA CEJA Opinion 1.2.3)

Physicians' fiduciary obligation to promote patients' best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care. When physicians seek or provide consultation about a patient's care or refer a patient for health care services, including diagnostic laboratory services, they should:

(a) Base the decision or recommendation on the patient's medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed.
(b) Share patients' health information in keeping with ethics guidance on confidentiality.
(c) Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service. Physicians should urge patients to familiarize themselves with any restrictions associated with their individual health plan that may bear on their decision, such as additional out-of-pocket costs to the patient for referrals or care outside a designated panel of providers.
(d) Explain the rationale for the consultation, opinion, or findings and recommendations clearly to the patient.
(e) Respect the terms of any contractual relationships they may have with health care organizations or payers that affect referrals and consultation. Physicians may not terminate a patient-physician relationship solely because the patient seeks recommendations or care from a health care professional whom the physician has not recommended.

FEE SPLITTING (Adapted from AMA CEJA Opinion 11.3.4)

Patients must be able to trust that their physicians will be honest with them and will make treatment recommendations, including referrals, based on medical need, the skill of other health care professionals or facilities to whom the patient is referred, the quality of products or services provided, and consistent with all federal and state laws.

Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical. *(HP)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

(Reaffirmed for One Year Pending Review at A-18)*
*(*Referred to Committee on Ethics, Grievances, and Professional Standards for Report Back)*
Adopted in lieu of Original MMS House of Delegates, 5/4/19

Finder's Fees

The Massachusetts Medical Society considers it unethical for physicians to accept finder's fees or any type of compensation or reward in return for referring patients to serve as research subjects for clinical research studies. *(HP)*

MMS House of Delegates, 5/20/95
Reaffirmed MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Genetic Information and Patient Privacy

The Massachusetts Medical Society adopts the following General Principles on Genetic Information and Patient Privacy:

1. Physicians should accord genetic information derived about their patients the highest possible confidentiality protection. Genetic information in the medical record should be handled so as to prevent inadvertent disclosure. Such information should be released to third parties only pursuant to the specific authorization of the patient. The possibility that genetic information derived about a patient might be of clinical importance to relatives or other third persons does not alter the physician's duty of confidentiality to his or her patients. The physician should, however, inform patients who are considering a genetic test about the potential importance of the data that could be derived there from to relatives. On very rare occasions, a physician may reveal otherwise confidential genetic information to a third person if withholding the genetic information derived from the patient will likely cause imminent and serious harm, injury or danger to that particular third person.

2. Physicians should strive to become aware of the special ethical, legal, social, financial, and personal issues that may arise when they or others compile genetic information about their patients.

3. Physicians engaged in genetic testing for clinical, therapeutic or research purposes should engage in such testing only with the full informed consent of the patient or, when appropriate, with the informed consent of the patient's legally authorized representative. Such informed consent should, at a minimum, involve a disclosure by the physician to the patient of the benefits, risks and costs associated with receiving the test, any appropriate alternative procedures or courses of treatment, the potential results of the test, any possible financial benefit to the physician, including any research interest, from either performing the test or utilizing the samples, and any other significant implications of receiving the test.

4. In cases where genetic samples have been intentionally donated for the purpose of genetics research in an anonymous manner (i.e., removed of or without identifiers), physicians need not obtain informed consent in order to engage in non-clinical use of such genetic testing results or samples.

5. Physicians should not order genetic testing of a child unless the test is intended to diagnose a disease or condition for which there is a recognized clinical benefit to acquiring the information before the child reaches the age of eighteen (18). Clinical benefit should be understood to include issues involving reproductive risks that are faced by adolescents (girls and boys), including those that arise in the context of an unplanned pregnancy. Such tests should be ordered only with the informed consent of the legally responsible person.

6. Physicians should participate in genetic research involving human subjects only if the research protocol has been approved by an institutional review board (IRB) or some comparable group that operates pursuant to federal guidelines involving human subjects research. They should satisfy themselves that adherence to the protocol will result in research subjects having adequate, fair disclosure concerning issues such as informational risk, long-term use and disposition of tissue samples, disclosure of research results to subjects, whether subjects will be recontacted if new information emerges, and relevant economic issues (such as whether the research is sponsored by a for-profit organization and/or whether a subject will or will not receive any economic benefit).

7. Genetic testing results can provide valuable information to be considered by individuals making reproductive choices. MMS opposes, however, the use of genetic testing results by persons or institutions, other than the

patient[s] from whom the genetic information was derived, to influence the reproductive choice of the patient[s] from whom the genetic information was derived.

(HP)

8. The Massachusetts Medical Society adopts AMA CEJA Opinion 4.1.3, Third Party Access to Genetic Information, which reads:

The rapid pace of development and dissemination of genetic testing has made it possible to generate information about individuals across a wide and growing spectrum of genetic variations associated with disease risk. The prospect of access to and use of such information by third parties who have a stake in an individual's health raises ethical concerns about confidentiality and potentially inappropriate use of genetic information.

Patients who undergo genetic testing have a right to have their information kept in confidence, and a variety of state and federal laws prohibit discrimination by employers, insurers, and other third parties based on genetic information they obtain about an individual.
Physicians who provide and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to:

(a) Maintain the confidentiality of the patient's health information, including genetic information.
(b) Release a patient's genetic information to third parties only with the patient's informed consent.
(c) Decline to participate in genetic testing at the request of third parties (for example, for purposes of establishing health care or other benefits or coverage for the individual) except when at the patient's request and with their informed consent.

(HP)
(MMS House of Delegates, 11/21/97)
(Reaffirmed MMS House of Delegates, 5/14/04)
Reaffirmed (Entire Policy) MMS House of Delegates, 5/21/11
(Amended and Reaffirmed MMS House of Delegates, 5/4/19)

9. The Massachusetts Medical Society will continue to monitor developments in the field of genetics, and if necessary, develop a plan to educate physicians throughout the state (through venues such as conferences and interactive or on-line learning tools, etc.), regarding the basic and current principles of genetic information and testing, and the clinical, social, and legal implications of such advancing technologies. *(D)*
(Amended and Reaffirmed MMS House of Delegates, 5/4/19)
Reaffirmed (Entire Policy) MMS House of Delegates, 5/21/11
Amended and Reaffirmed (Entire Policy) MMS House of Delegates, 5/4/19

Gifts to Physicians from Industry
The Massachusetts Medical Society adopts the following updated policy, set forth in Opinion 9.6.2 of the American Medical Association Code of Ethics, "Gifts to Physicians from Industry," which reads as follows:

Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing — or being perceived to bias — professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

Decline cash gifts in any amount from an entity that has a direct interest in physicians' treatment recommendations.

Decline any gifts for which reciprocity is expected or implied.

Accept an in-kind gift for the physician's practice only when the gift:
will directly benefit patients, including patient education; and is of minimal value

Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students', residents', and fellows' participation in professional meetings, including educational meetings, provided:

the program identifies recipients based on independent institutional criteria; and

funds are distributed to recipients without specific attribution to sponsors.
(HP)

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Health Facility Ownership by Physicians
Physicians' Self-Referral
The Massachusetts Medical Society (MMS) adopts the American Medical Association Council on Ethical and Judicial Affairs Opinion 9.6.9, "Physicians' Self-Referral," which reads as follows:
Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.
(2) Ensure that the arrangement:
(a) is structured to enhance access to appropriate, high quality health care services or products; and
(b) within the constraints of applicable law:
(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
(iii) adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
(3) Take steps to mitigate conflicts of interest, including:
(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
(b) establishing mechanisms for utilization review to monitor referral practices; and
(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral. (II, III, VIII)
Issued June 2009 based on the report "Physicians' Self-Referral," adopted November 2008.
(HP)

MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/17/14
Amended (just the Opinion # changed) and Reaffirmed MMS House of Delegates, 5/21/22

Medical Education/Performing Procedures
The Massachusetts Medical Society urges medical schools to adopt and inform medical students of the policy that they may refuse to perform procedures during medical education that are contrary to their religious or moral beliefs without repercussions to the student. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Medical Ethics
The MMS will monitor the statements related to medical ethics adopted by the American Medical Association and other sources periodically, as events and circumstances demand, no less than every three years. *(D)*

The MMS will inform the membership at large, and particularly those eligible to vote in the House of Delegates, of any significant developments in the evolution of medical ethics periodically as events and circumstances demand, at least every three years, so as to expedite any amendments to our ethical policies as may then seem appropriate. *(D)*

The Chair of the MMS Delegation to the American Medical Association (AMA) will transmit actions of the AMA Council on Ethical and Judicial Affairs (CEJA) to our committee on Ethics, Grievances and Professional Standards every year. *(D)*

MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society supports the embodiment of the Massachusetts Medical Society Code of Ethics, as amended from time to time, within the Medical Staff Bylaws of all Massachusetts hospitals, clinics, and other health care facilities structured by such internal governance. *(HP)*

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society adopts as its Code of Ethics the revised American Medical Association's Principles of Medical Ethics (adopted June 17, 2001), which read as follows:
Principles of Medical Ethics:

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.
II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.
III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.
V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.
VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.
VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
IX. A physician shall support access to medical care for all people.

(HP)

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The Code of Medical Ethics of the Council on Ethical and Judicial Affairs of the American Medical Association shall serve as a guide to the MMS in interpreting existing ethical policies and in promulgating new ethical policies for physicians.

The Committee on E&D shall hold an open forum on ethical issues at each regular meeting of the HOD, with an advance notice of the agenda distributed, to encourage attendee input.

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Notification of Physician Departure
The Massachusetts Medical Society adopts the following principles relating to Patient Notification Upon Departure of a Physician from a Practice, and will share this policy with health systems and provider organizations and educate the membership about this policy:

The patient panel of a physician who leaves a practice, including an employed physician, shall be notified in writing in a timely manner of the physician's departure. When used in this policy, the phrase "patient panel" is intended to denote those patients with whom the physician has a direct and ongoing relationship.

If the departing physician will be available to continue to provide care to said patient, the notification letter must include the departing physician's forwarding address and telephone number.

Absent an agreement to the contrary, the custodian of the medical record is responsible for patient notification.

The Massachusetts Medical Society considers it unethical to withhold said patient notification. *(HP/D)*

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Patenting of Medical and Surgical Procedures
The Massachusetts Medical Society condemns the patenting of medical and surgical procedures. *(HP)*

MMS House of Delegates, 5/19/95
Reaffirmed MMS House of Delegates, 5/31/02
Item 1 of Original: Amended and Reaffirmed MMS House of Delegates, 5/8/09
(Item 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society (MMS) condemns the patenting of surgical methods or procedures. The MMS strongly supports federal laws to prohibit the patenting of surgical methods or procedures.

MMS House of Delegates, 11/19/94
Reaffirmed MMS House of Delegates, 5/11/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Patient Testimonials
The Massachusetts Medical Society adopts the following policy, adapted from the American Medical Association Council on Ethical and Judicial Affairs Opinion E-9.6.1, "Advertising and Publicity," updated June 1996, which reads as follows:

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct

mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the communication so that the information contained therein is readily comprehensible to the public. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading.

The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other non-deceptive information.

Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.
Any patient testimonial (whether by an individual or a group of patients) should be representative of what patients will generally achieve under similar circumstances. Therefore, unless the physician possesses and relies upon adequate substantiation for this representation, the communication should clearly and conspicuously disclose (1) what the generally expected results would be in the depicted circumstances or (2) the limited applicability of the testimoniant's experience to what patients may generally expect to achieve. Any patient testimonial should be by actual patients or should clearly and conspicuously disclose that the persons are not actual patients.

Any financial, business, or other relationship between the testimoniant and the physician should be fully disclosed. Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable.

Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

The MMS discourages the solicitation of a testimonial from any current or former patient. Physicians should exercise particular care if soliciting any current or former patient to provide a testimonial so as to avoid any undue influence on or exploitation of that patient.

Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, television, the Internet, or in any other medium, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met.
(HP)

MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
(Opinion Number, only, Amended, Policy Reaffirmed MMS House of Delegates, 5/21/22)

Referrals
It shall be unethical for physicians to accept compensation from clinics, laboratories, hospitals, or other health care facilities for the referral of patients, because such compensation constitutes fee splitting. *(HP)*

MMS House of Delegates, 11/19/94
Reaffirmed MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Sale of Health-Related Products from Physicians' Offices
The sale of health-related products by physicians can offer convenience for patients, but can also pose ethical challenges. "Health-related products" are any products other than prescription items that, according to the manufacturer or distributor, benefit health. "Selling" refers to dispensing items from the physician's office or website in exchange for money or endorsing a product that the patient may order or purchase elsewhere that results in remuneration for the physician.

Physician sale of health-related products raises ethical concerns about financial conflict of interest, risks placing undue pressure on the patient, threatens to erode patient trust, undermine the primary obligation of physicians to serve the interests of their patients before their own, and demean the profession of medicine.

Physicians who choose to sell health-related products from their offices or through their office website or other online venues have ethical obligations to:

(a) Offer only products whose claims of benefit are based on peer-reviewed literature or other sources of scientific review of efficacy that are unbiased, sound, systematic, and reliable. Physicians should not offer products whose claims to benefit lack scientific validity.

(b) Address conflict of interest and possible exploitation of patients by:

(i) Fully disclosing the nature of their financial interest in the sale of the product(s), either in person or through written notification, and informing patients of the availability of the product or other equivalent products elsewhere.

(ii) Limiting sales to products that serve immediate and pressing needs of their patients (e.g., to avoid requiring a patient on crutches to travel to a local pharmacy to purchase the product). Distributing products free of charge or at cost makes products readily available and helps to eliminate the elements of personal gain and financial conflict of interest that may interfere, or appear to interfere with the physician's independent medical judgment.

(c) Provide information about the risks, benefits, and limits of scientific knowledge regarding the products in language that is understandable to patients.

(d) Avoid exclusive distributorship arrangements that make the products available only through physician offices. Physicians should encourage manufacturers to make products widely accessible to patients.

MMS House of Delegates, 12/3/05
Reaffirmed MMS House of Delegates, 5/19/12
Amended and Reaffirmed MMS House of Delegates, 12/4/20

Sexual Harassment/Misconduct
The Massachusetts Medical Society unequivocally disapproves and rejects any and all forms of sexual harassment. *(HP)*

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 11/4/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society considers sexual misconduct of physicians with patients to be unethical. Physicians must not use their role in an exploitative manner. *(HP)*

MMS Council, 2/14/90
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

Stem Cell Research – Federal Funding of
The Massachusetts Medical Society (MMS) supports in principle the concept that, to further the well-being of humanity, it is ethically imperative that federal funding for ethically conducted medical research involving human embryonic pluripotent stem cells and other sources of stem cells (cord, adult), including cloning for therapeutic purposes, should not in any manner be limited or restricted for any reason other than ordinary budgetary constraints. *(HP)*

MMS House of Delegates, 11/9/02
Amended and Reaffirmed MMS House of Delegates, 5/8/09
Item 1: Reaffirmed MMS House of Delegates, 5/7/16
(Item 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/13/23

FIREARMS: SAFETY AND REGULATION

Assault Weapons
The Massachusetts Medical Society supports a statewide ban on the sale and/or possession of assault weapons by private citizens in Massachusetts. *(HP)*

MMS House of Delegates, 5/19/95
Reaffirmed MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Concealed Carry
The MMS will oppose all forms of "concealed carry reciprocity" federal legislation that would require all states to recognize concealed carry permits granted by other states and allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws. *(D)*

MMS House of Delegates, 4/28/18
(Item 2 of Original: Auto-Sunset: Time-Limited Directive Completed MMS House of Delegates, 12/1/18)

Firearms
The MMS will advocate for and strongly support legislation, regulation, and reform that seeks to address the public health crisis posed by gun violence. *(D)*

The MMS will ask the AMA to advocate for and strongly support legislation, regulation, and reform that seeks to address the public health crisis posed by gun violence. *(D)*

MMS House of Delegates, 12/9/23

The MMS is guided by the principles of reducing the number of deaths, disabilities, and injuries attributable to firearms; making firearm ownership safer; and promoting education relative to firearms, ammunition, and violence prevention for physicians, other health professionals and the public.; To this end, the MMS encourages evidence-based research to reduce firearm injury and death. *(HP)*

The MMS encourages health care providers to review firearm safety as a routine component of preventive care. *(HP)*

The MMS promotes and supports state legislative efforts to make licensing and background checks mandatory for all sales of firearms regardless of the seller. *(HP)*

The MMS reaffirms its advocacy for the right of physicians to discuss firearm safety and the ownership and storage of firearms within the duty and privacy of obtaining a medical history. *(HP)*

The MMS offers education to physicians and other health care providers concerning instituting a firearm safety discussion. *(HP)*

The MMS continues to seek and support efforts, within the framework of the Society's existing publications and communications, to diminish the menace of firearm violence in America and beyond on behalf of the public's health. *(HP)*

MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20
(Item 4 of Original: Sunset MMS House of Delegates, 12/5/20)

The Massachusetts Medical Society is strongly opposed to legislative interference in the right of physicians and patients (or their parents or guardians) to discuss gun ownership, storage, and safety in the home. (*D*)

The MMS records its opposition to any legislative or regulatory limits on a physician's ability to take a complete history and document relevant portions of the history into the permanent medical record. (*D*)

The MMS will advocate that the AMA take a leadership role in opposing legislative interference in the physician-patient relationship and the physician's efforts to discuss and record the patient's history, including questions about gun safety. (*D)*

MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Public Policy

1. The Massachusetts Medical Society supports prohibiting firearm sales to or transport by persons under the age of 21.
2. The Massachusetts Medical Society supports penalties for adults who leave firearms accessible to children under the age of 18.
3. The Massachusetts Medical Society supports education of the general public about the inherent dangers of firearms and firearm safety measures and precautions.
4. The Massachusetts Medical Society encourages physicians to broaden medical evaluations to include a screening for risk of harm to self and others from access to firearms.

Education

1. The Massachusetts Medical Society supports the education of physicians about the epidemic of firearm violence in all its forms and will work with local agencies and organizations who share goals of eliminating or reducing violence through education and comprehensive regulatory and legislative measures.
2. The Massachusetts Medical Society supports efforts to educate licensed firearms dealers on the health implications of firearm injuries and violence.
3. The Massachusetts Medical Society supports education of the general public about the epidemic of firearm violence within the framework of the Society's existing publications and communications and by collaboration with the Massachusetts Department of Public Health and other stakeholders.
4. The Massachusetts Medical Society supports the education of physicians and other healthcare providers, families, and communities, regarding the importance of reducing and limiting violent media programming for entertainment purposes (movies, TV, video, radio, etc.) when children are viewing.

Collaboration

1. The Massachusetts Medical Society supports laws, regulations, and policies that would require firearm manufacturers to invest in ongoing efforts to improve safety technologies.
2. The Massachusetts Medical Society supports measures requiring firearm manufacturers to engineer childproofed handguns.
3. The Massachusetts Medical Society supports measures requiring that firearms must pass minimum safety standards and not be made of inferior materials, not be made on 3D printers, not be prone to firing based on a

single pull of the trigger, not be prone to the explosion of the firearm during firing with standard ammunition, and not be prone to accidental discharge.

4. The Massachusetts Medical Society supports the ongoing review of what is considered "minimum safety standards" in light of improving safety technologies.
5. The Massachusetts Medical Society supports a ban on the sale of small, inexpensive, and poorly manufactured junk firearms.
6. The Massachusetts Medical Society supports the imposition of a tax on all firearm sales, new or used, with revenue directed toward public education regarding firearm safety.
7. The Massachusetts Medical Society supports continued efforts to strengthen the dealer licensing system requiring that ammunition be sold only through licensed dealers, and that it only be sold to licensed holders.
8. The Massachusetts Medical Society supports the prohibition of firearm ownership by people convicted of felonies and those convicted of the misdemeanor crime of domestic violence.
9. The Massachusetts Medical Society supports adding a new category of prohibited [firearm] buyers – child abusers.
10. The Massachusetts Medical Society supports prohibiting firearm possession by persons under the age of 18.
11. The Massachusetts Medical Society supports halting the sale and manufacture of lethal types of ammunition that have no use in hunting game or sports.
12. The Massachusetts Medical Society joins with other organizations working to reduce firearm violence, to increase the efficiency of our advocacy on issues for which we share common policies.

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
(Items 1, 3, 4, Education) Amended and Reaffirmed MMS House of Delegates, 5/21/11
(Item 1, Public Policy) Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Item 2, Education) Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Items 4-6, 7-8, and 10-12, Collaboration) Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Additional Items Sunset MMS House of Delegates, 5/21/11 and 5/19/12)
(Item 13) Reaffirmed MMS House of Delegates, 5/19/12
(Item 5, Education) Amended and Reaffirmed MMS House of Delegates, 5/11/13
(Item 2, Collaboration) Reaffirmed MMS House of Delegates, 5/11/13
(Items 1-4, Public Policy) Amended and Reaffirmed MMS House of Delegates 12/5/20
(Items 1-4, Education) Amended and Reaffirmed MMS House of Delegates 12/5/20
(Items 2-3, 5, 8-10, 12, Collaboration) Amended and Reaffirmed MMS House of Delegates 12/5/20)

HEALTH CARE DELIVERY

Accountable Care Organizations

The MMS adopt the following criteria as policy for physicians who are considering participation in accountable care organizations (ACOs) or integrated delivery systems:

1. Flexibility: Membership criteria should be well defined and clearly communicated, but should offer a level of flexibility and leeway for continued improvement and change. In addition, an ACO's criteria for participation should be flexible enough to allow consideration of physicians who may not meet the full spectrum of an ACO's defined membership requirements.

2. Eligibility: Physicians should be licensed in the state in which the ACO operates. Physicians should be eligible to participate in an ACO if they are clinically qualified to practice medicine or deliver the relevant required services for the ACO; and able to meet the terms of the ACO contract. Physicians that meet eligibility guidelines should be considered as members, however acceptance by an ACO is not mandatory.

3. Quality-of-Care Standards: Physicians should be informed of the performance measurement expectations of an integrated delivery system (IDS) or ACO, in order to best determine if they can meet or exceed expected quality and performance benchmarks that are outlined by the ACO or integrated delivery network (IDN). More specifically, participants should have enough information to determine their capacity to meet or exceed quality-of-care performance measures within several categories, such as: a) Patient/caregiver experience; b) Care coordination/patient safety; c) Preventative health; and d) At-risk population specific measures.

4. Financial Standards: Physicians should be informed of the performance measurement expectations (if applicable) of an IDS or ACO, in order to best determine if they can meet the financial expectations required to participate in the ACO. Expectations regarding revenue sharing should be available in order for ACO participants to understand the potential to receive shared savings. Physicians should have the opportunity to evaluate whether or not they are able to consistently meet these financial expectations over time. Potential participants should be provided with financial reports at the point of contracting so that the baseline financials are understood. Routine reporting on financial performance in relation to expectations should be provided. Physicians should have the opportunity to review, ask questions, and understand that they have the ability to appeal incorrect financial data.

5. Clinical-Practice Standards: Physicians should be informed of the performance measurement expectations of an ACO, in order to best determine if they can meet or exceed clinical-practice standards, such as a) Promoting evidence-based medicine; b) Promoting patient engagement; c) Reporting internally on quality and cost metrics; and d) Coordinating care. Prospective ACO participants should ensure that they are capable of meeting patient-centeredness measures. Additionally, physicians should be certain that they have the ability to develop individualized care plans, based on a patient's unique needs, preferences, values, and priorities. As physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients, they should lead all clinical teams and approve all clinical protocols to be used by other members of the clinical team.

6. Data Use and Interoperability: Physicians should be informed of the need to have, or the need to be willing to, implement, a system that will send and receive electronic transactions through an electronic medical record (EMR) system. ACOs and IDNs should support participating physicians by providing them with data collection tools and timely reports to help physicians be able to use the data in a meaningful way in order to provide quality patient care in the practice setting.

   Transparent, accessible health data (including cost and quality information) should be accessible to the participating physician so that those data may be used to make informed, data-driven decisions. While participating physicians should not be forced to switch EMRs as a condition of participation, the EMR system used should be capable of performing the required functions to comply with state and federal regulations that support Health Information Exchange initiatives and other such initiatives that require information to be exchanged among health care entities.

7. Governance: In accordance with AMA principles on ACOs, physicians who participate in an ACO or an IDN should make medical decisions that are not based on commercial interests, but rather on professional medical judgment that puts patients' interests first. This should be a clear mandate from all parties involved. Physician participation in ACO governance is key to the success of the ACO, and as such, physicians should be aware of board membership roles and

responsibilities. Ensuring the option for such participation is an important decision point. Given the responsibility, detailed governance-based roles should be clearly outlined and communicated to ACO participants up front.

8. Leadership Participation: Physician leadership is the hallmark of the ACO model; therefore physicians should be prepared to undertake the different responsibilities and expectations of leadership roles. ACO leaders should participate in establishing practice methods, strategic initiatives, and quality initiatives that are efficient and effective. Physician decisions directly impact the quality of care delivered as well as utilization and costs.

9. Management and Administrative Structure: The ACO or integrated delivery model structure should be clearly outlined for the physician at the point of contracting. Any changes that the physician may have to make should be clear so the physician can determine whether or not the changes are possible. Physicians should be able to communicate and work with staff to ensure that they are aligned with the goals and strategy of the ACO. ACO or IDN management and administrative structures should be made clear to the physician participant to allow them to adapt to the ACO's model.

10. Patient-Panel Contribution: Physicians should be able to accept and be accountable for a population of patients. Specific requirements may exist that require physicians to maintain in-network referrals. Physicians must be free to refer out of the network if it is in the patient's best interest. Physicians and the ACO should have mechanisms in place to address the reality that patient compliance and some variables may be outside the physicians' control. Physicians should be willing to assist in the development of protocols regarding patient care coordination.

11. Legal Compliance: ACOs and integrated delivery networks should provide a description of legal requirements to physicians at the point of contracting so the physician understands what federal, state, local, and ACO legal requirements they have to comply with. Key areas of consideration include: a) Antitrust; b) Anti-Kickback Statute; c) Stark Law; d) False Claims Act; e) Civil Monetary Penalty statute. Moreover, physicians must understand ahead of time and be compliant with the terms of the ACO's or integrated delivery system's rules and regulations (for contractual compliance please see Item number 12).

12. Contractual Compliance: Physicians should understand and comply with the terms of their contract. Physicians interested in joining an ACO should be provided with an upfront copy of the contract in order to understand the contractual terms of the ACO agreement prior to joining the ACO. Contractual compliance should be clearly outlined and a timeframe for physician review (and legal consultation) should be allowed. Physicians should be allowed enough time to ascertain whether or not they will be able to submit to the specific contractual requirements outlined in the agreement. Contracts should include clear non-compliance/termination clauses as outlined in Item number 13, and clear mechanisms for grievance processes.

13. Terms of Non-Compliance/Termination: Physicians should be able to terminate their relationship with an ACO or IDS at will within contractually designated time frames for notification. In addition, there is no guarantee that acceptance of a physician into an ACO will mean permanent placement. Physicians should be aware of contractually defined non-compliance and termination clauses in advance of joining the ACO. Clauses should clearly define:

    a. The terms required for physicians to maintain their participation in an ACO
    b. The expected cost and quality benchmarks that a physician must maintain in order to remain compliant
    c. The process a physician would follow if deciding to terminate the relationship with an ACO
    d. The process that would occur if an ACO were to seek termination of the relationship with a physician
    e. The opportunity for review and appeal in the event that a physician felt he or she was being wrongfully terminated from an ACO agreement

14. Termination of contract between physician and ACO should not in and of itself be a reportable event to the Board of Registration in Medicine.

(HP)

MMS House of Delegates, 12/7/13
Item 10: Amended and Reaffirmed, MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/21/22

The MMS adopts the-principles concerning accountable care organizations (ACOs)-adopted by the American Medical Association (AMA) at their 2010 Interim Meeting, with MMS amendments as follows:

American Medical Association Accountable Care Organization (ACO) principles as adopted at the AMA's 2010 Interim Meeting

1. Guiding Principle — The goal of an Accountable Care Organization (ACO) is to increase access to care, improve the quality of care and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.

2. ACO Governance — ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients' interests first.

   Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. The AMA supports true collaborative efforts between physicians, hospitals and other qualified providers to form ACOs as long as the governance of those arrangements ensure that physicians control medical issues.

   The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician-entity [e.g., Independent Physician Association (IPA), Medical Group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.

   The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area.

   Where a hospital is part of an ACO, the governing board of the ACO should be separate, and independent from the hospital governing board.

3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer or being admitted to a hospital medical staff.

4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small- and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

6. Additional resources should be provided up-front in order to encourage ACO development. CMS's Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the "shared savings" model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

   The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

   The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

   The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index) and physician HIT costs.

   The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

   In addition to the shared savings earned by ACOs, ACOs that spend less than the national average per Medicare beneficiary should be provided an additional bonus payment. Many physicians and physician groups have worked hard over the years to establish systems and practices to lower their costs below the national per Medicare beneficiary expenditures. Accordingly, these practices may not be able to achieve significant additional shared savings to incentivize them to create or join ACOs. A bonus payment for spending below the national average would encourage these practices to create ACOs and continue to use resources appropriately and efficiently.

8. The quality performance standards required to be established by the Secretary must be consistent with AMA policy regarding quality. The ACO quality reporting program must meet the AMA principles for quality reporting, including the use of nationally-accepted, physician specialty-validated clinical measures developed by the AMA-specialty society quality consortium; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; and the right for physicians to appeal inaccurate quality reports and have them corrected. There must also be timely notification and feedback provided to physicians regarding the quality measures and results.

9. An ACO must be afforded procedural due process with respect to the Secretary's discretion to terminate an agreement with an ACO for failure to meet the quality performance standards.

10. ACOs should be allowed to use different payment models. While the ACO shared-savings program is limited to the traditional Medicare fee-for-service reimbursement methodology, the Secretary has discretion to establish ACO demonstration projects.

    ACOs must be given a variety of payment options and allowed to simultaneously employ different payment methods, including fee-for-service, capitation, partial capitation, medical homes, care management fees, and shared savings. Any capitation payments must be risk-adjusted.

11. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey should be used as a tool to determine patient satisfaction and whether an ACO meets the patient-centeredness criteria required by the ACO law.

12. Interoperable Health Information Technology and Electronic Health Record Systems are key to the success of ACOs. Medicare must ensure systems are interoperable to allow physicians and institutions to effectively communicate and coordinate care and report on quality.

13. If an ACO bears risk like a risk bearing organization, the ACO must abide by the financial solvency standards pertaining to risk-bearing organizations.

(HP)

The AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. *(HP)*

The MMS will make available to members by electronic means and in hard copy, upon request, specific MMS principles concerning accountable care organizations and the provision of accountable care. *(D)*

MMS House of Delegates, 5/19/12
Amended and Reaffirmed MMS House of Delegates, 12/5/20
Reaffirmed MMS House of Delegates, 12/5/20
(Item 13 of Original Principles Amended and Reaffirmed MMS House of Delegates, 12/5/20)
(Policy/Directive 2-3 of Original Sunset MMS House of Delegates, 12/5/20)

Artificial Intelligence

The MMS strongly supports that Artificial Intelligence (AI) developers and relevant stakeholders work together with clinicians and other health care providers to ensure the responsible use of AI in medicine. *(HP)*

The MMS will advocate to Artificial Intelligence (AI) developers, health systems, payers, and provider organizations that AI in medicine is used in a safe, ethical, and equitable manner to improve the lives of patients. *(D)*

MMS House of Delegates, 12/9/23

Bias Mitigation

The MMS supports educational efforts on bias mitigation strategies for health care professionals with the goal of improving the impact on patient care. *(HP)*

The MMS supports using the knowledge from the educational efforts on bias mitigation strategies in order to recognize potential implicit and explicit bias in medical notes and other forms of communication between medical professionals. *(HP)*

MMS House of Delegates, 5/13/23

Care for Military Casualties

The Massachusetts Medical Society will work with the American Medical Association and state and federal officials to ensure that casualties from our current military conflicts receive quality medical care using civilian and federal medical resources as appropriate. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Clinical Integration

The MMS will continuously monitor AMA activity regarding health care laws, regulations, and model organizational information for physicians (including independent, small groups) and medical staffs. This information will assist members with communicating, organizing, and participating in care processes for the high quality and efficient service delivery of health care that will permit independent physician practitioners and/or small groups to clinically integrate and provide accountable care. *(D)*

The MMS will make AMA activity regarding legal and model organizational information on practice integration available to MMS members, by electronic means — as well as on the MMS website — and in hard copy upon request. *(D)*

MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Complementary and Alternative Medicine
The Massachusetts Medical Society (MMS) encourages physicians to become better informed regarding the practices and techniques of Complementary and Alternative Medicine (CAM) so they may be better able to discuss, when appropriate, the benefits and risks of such practices. This may include relevant patient safety issues related to possible interactions between CAM and traditional treatments, as well as matters of professional liability regarding informed consent, standards of care, and referrals to CAM providers. *(HP)*

The MMS recommends that courses on CAM offered by medical schools include a scientific analysis of the potential therapeutic utility, safety, and efficacy of these modalities. *(HP)*

The MMS endorses the AMA policies on CAM including support of the research efforts of the National Institutes of Health's National Center for Complementary and Alternative Medicine. *(HP)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Direct Primary Care
The Massachusetts Medical Society will advocate for changes in federal law to establish that Direct Primary Care membership fees may be paid with pre-tax funds. *(D)*

The Massachusetts Medical Society will advocate for passage of state legislation to establish the right of patients to seek care from specialists who are contracted with their insurance plan and to have that service covered when referred by a primary care physician who is not contracted with their insurance plan. *(D)*

MMS House of Delegates, 12/2/17

Discharge Planning Process
The Massachusetts Medical Society adopts the following adapted from American Medical Association policy:

1. The MMS will continue its advocacy to expedite interoperability of electronic health record (EHR) systems, standardize key EHR elements, and engage the vendor community to promote improvements in EHR usability. *(D)*

2. The MMS supports evidence-based discharge criteria and principles regarding discharge planning, teamwork, communication, responsibility/accountability among attending physicians and continuing care providers, as well as the transfer of pertinent patient information and the discharge summary. *(HP)*

3. The MMS will advocate for timely and consistent communication between physicians in inpatient and outpatient care settings to decrease gaps in care coordination and improve quality and patient safety, and to explore new mechanisms to facilitate and incentivize this communication. *(D)*

4. The MMS encourages the initiation of the discharge planning process, whenever possible, at the time patients are admitted for inpatient or observation services and, for surgical patients, prior to hospitalization. *(HP)*

5. The MMS supports the development of discharge summaries that are presented to physicians in a meaningful format that prominently highlight salient patient information, such as the discharging physician's narrative and recommendations for ongoing care. *(HP)*

6. The MMS supports hospital engagement of patients and their families/caregivers in the discharge process, using the following guidelines:
    a. Information from patients and families/caregivers is solicited during discharge planning, so that discharge plans are tailored to each patient's needs, goals of care and treatment preferences.

b. Patient language proficiency, literacy levels, cognitive abilities and communication impairments (e.g., hearing loss) are assessed during discharge planning. Particular attention is paid to the abilities and limitations of patients and their families/caregivers.
c. Specific discharge instructions are provided to patients and families or others responsible for providing continuing care both verbally and in writing. Instructions are provided to patients in layman's terms, and whenever possible, using the patient's preferred language.
d. Key discharge instructions are highlighted for patients to maximize compliance with the most critical orders.
e. Understanding of discharge instructions and post-discharge care, including warning signs and symptoms to look for and when to seek follow-up care, is confirmed with patients and their families/caregiver(s) prior to discharge from the hospital.

(HP)

7. The MMS supports making hospital discharge instructions available to patients in both printed and electronic form, and specifically via online portals accessible to patients and their designated caregivers. *(HP)*
8. The MMS supports implementation of medication reconciliation as part of the hospital discharge process. The following strategies are suggested to optimize medication reconciliation and help ensure that patients take medications correctly after they are discharged:
    a. All discharge medications, including prescribed and over-the-counter medications, should be reconciled with medications taken pre-hospitalization.
    b. An accurate list of medications, including those to be discontinued as well as medications to be taken after hospital discharge, and the dosage and duration of each drug should be communicated to patients.
    c. Medication instructions should be communicated to patients and their families/caregivers verbally and in writing.
    d. For patients with complex medication schedules, the involvement of physician-led multidisciplinary teams in medication reconciliation including, where feasible, pharmacists should be encouraged.

    (HP)

9. The MMS encourages patient follow-up in the early time period after discharge as part of the hospital discharge process, particularly for medically complex patients who are at high-risk of re-hospitalization. *(HP)*

10. The MMS encourages hospitals to review early readmissions and modify their discharge processes accordingly. *(HP)*

11. The MMS will work with the AMA to develop model guidelines for physicians to improve communications to other physicians, hospital staff, and patients; incorporate these guidelines into the MMS Model Medical Staff Bylaws; and promote these guidelines to payers, hospitals, and patients. *(D)*

MMS House of Delegates, 4/29/17

Hospital Integrated ACOs/Cost Savings Failure

The MMS will advocate that the MA Health Policy Commission and Center for Health Information Analysis (CHIA) assess the effect of hospital-integrated system Accountable Care Organizations' (ACOs) failure to generate savings on downsizing of the medical staff and further consolidation of medical practices. *(D)*

The MMS will advocate that the MA Health Policy Commission and CHIA research the root causes for failure to generate savings in hospital-integrated ACOs, as compared to physician-owned ACOs, including the range of services, differences in the cost of facility charges, higher utilization of expensive services, overhead due to health information technology, administration, practice acquisitions, and the more complex infrastructure necessary to create and manage a larger ACO. *(D)*

MMS House of Delegates, 5/4/19

MassHealth ACO/Social Determinants of Health

The MMS supports a requirement to create partnerships between Social Service Organizations and Accountable Care Organizations (ACOs) to facilitate MassHealth's extension of services for health-related social needs. *(HP)*

The MMS will work with MassHealth to learn about the screening tools and collection processes used by Accountable Care Organizations to ensure data collection consistency and comparison capability with regard to health-related social needs. *(D)*

The MMS will advocate to MassHealth to release more evidence-based data on the effectiveness and capabilities of MassHealth Community Partners Behavioral Health and Long-Term Services and Supports and Social Service Organizations to improve their use. *(D)*

The MMS supports pay for process implementation, pay for reporting, and pay for performance as it related to the process of screening for health-related social needs, but MMS does not support pay for outcomes associated with referrals for social determinants of health as measures are not yet created and are therefore still in their infancy. *(HP)*

The MMS will continue to educate physicians and health care professionals about the MassHealth ACO program and its screening processes in support of social determinants of health needs. *(D)*

The MMS will continue to monitor the MassHealth ACO program including its roll out of the Flexible Spending Program, which is intended to provide scaffolding in support of nutrition and housing support services. *(D)*

MMS House of Delegates, 5/4/19

Mental Health Care/Communications with Primary Care/Referring Physicians

The MMS will develop guidelines for standardized and prioritized timely communication between mental health, primary care, and all referring clinicians, which includes at least diagnoses, treatment plan, medication plan, and specific follow-up instructions. *(D)*

The MMS will collaborate with vested stakeholders to implement and disseminate guidelines for acute psychiatric follow-up care in a timely manner to attain and ensure optimal mental health follow-up care. *(D)*

MMS House of Delegates, 12/5/20

Mental Health: College/University Students

The MMS supports accessibility and destigmatization as strategies in mental health measures implemented by colleges and universities, in order to improve the provision of care and increase its use by those in need. *(HP)*

The MMS supports colleges and universities in publicizing the importance of mental health resources, with an emphasis on the availability and efficacy of such resources. *(HP)*

The MMS supports collaborations of university mental health specialists and local health centers in order to provide a larger pool of resources, such that any student be able to access care in a timely and affordable manner. *(HP)*

MMS House of Delegates, 4/29/17

Mental Health: LGBTQIA Resources in Schools

The MMS work will with appropriate stakeholders to provide lesbian, gay, bisexual, transgender, queer, intersex, and asexual youth with access to mental health resources through schools in Massachusetts. *(D)*

MMS House of Delegates, 5/13/23

Mental Health Services Principles

The Massachusetts Medical Society (MMS) is opposed to mental health carve-outs for the provision of behavioral health services because of concerns regarding the impact of carve-out arrangements on patient access to high quality health care. These concerns include lack of parity in payment and processes, fragmentation of the medical and mental health care systems; management techniques which limit provider networks; adherence to patient confidentiality; and the disruption of communication, collaboration, and continuity of care for patients with mental health and substance use disorders.

The MMS advocates that all health plans/insurers offer mental health and substance use services which adhere to the following principles and that entities that evaluate such plans for the purposes of accreditation use these principles for evaluation:

READY ACCESS TO PERSONALIZED MENTAL HEALTH REFERRALS

• Include the provision of appropriate and timely diagnosis, assessment, and treatment of behavioral health disorders.

• Employ locally based management, medical, and other professional personnel familiar with the physicians, other health care professionals, and facilities in the contracted network.

• Make available and widely disseminate a current and accurate provider network list and access information to enrollees through several mechanisms that include phone, fax, paper and Web access.

• Allow patients to be linked to local network psychiatrists and other mental health professionals accepting new patients with minimum wait time.

MEANINGFUL INTEGRATION WITH THE MEDICAL CARE SYSTEM

• To the maximum extent possible, encourage the natural referral patterns between PCPs and mental health professionals through active outreach to PCPs, hospitals and medical groups.
• Open networks to qualified mental health professionals.

• Encourage clinical collaboration between PCPs and mental health professionals in the planning, authorizing and delivering of intensive psychiatric services, such as inpatient services, day treatment, and medically necessary psychotherapy.

• Adopt Collaborative Care Model (CoCM) CPT billing codes and Behavioral Health Integration (BHI) CPT codes to facilitate adoption of the CoCM and other BHI services.

COMPLIANCE WITH THE PRINCIPLES OF PARITY AND RELEVANT STATE AND FEDERAL PARITY STATUTES

• Review and authorization processes should be no different than those for physical illness.

• Insurance company practices and policies should be transparent to physicians, other health care professionals, and patients and be administered equally for medical and mental health services, including parity between medical, mental health, and substance use services. If medical services are administered locally, so should mental health services.

• Ensure payment parity for mental health professionals in line with physical health professionals as outlined by federal and state law.

STRICT CONFIDENTIALITY AND SENSITIVITY TO STIGMATIZATION

• Prevent stigmatization for patients who seek mental health and substance use services.

• Adhere to state and federal privacy statutes regarding confidentiality including HIPAA and relevant state privacy statutes.

• Promote active efforts to ensure patient dignity and elimination of potential barriers to service, such as voice mail mazes, unnecessary intake questions and difficulty accessing psychiatrists and other mental health professionals.

• Use appropriately trained and supervised case managers and screeners, with relevant and age-group-specific mental health and substance use training, with specific attention to language and cultural needs of patients to authorize access to behavioral health services.

• To protect the privacy and confidentiality of a patient's records, only the patient information necessary to confirm the need for mental health and substance use services should be elicited by insurance carriers.

STREAMLINED AUTHORIZATION & CONTINUING REVIEW PROCEDURES

• Use evidence-based criteria for authorization of continuing care in managed care plans.

• Primary care and mental health and substance use treatment physicians and other health care professionals should determine the quantity and length of their own visits, not carriers applying arbitrary limits on treatment. Physicians and other health care professionals should determine the length and type of visit according to their clinical assessment, which includes automatic authorization of initial phases of assessment and treatment of behavioral health disorders.

• Eliminate unnecessary review of routine care which is in compliance with federal and state parity statutes. Whenever a cap on the number of mental health visits is imposed, require insurance companies to provide recertification for additional visits upon request by the treating psychiatrist or other health care professional without additional personal information from the patient.

• Allow immediate internal appeal by a physician for denials of service and make readily available third-party review of denials for seriously ill psychiatric patients.

• Eliminate burdensome and redundant paperwork.

AVAILABILITY OF INTENSIVE SERVICES TO THE SERIOUSLY PSYCHIATRICALLY ILL

• Ensure availability of case management services for every patient with complex mental health needs.

• Provide easy access to medically necessary outpatient, crisis intervention, inpatient services, residential services, and day treatment when deemed necessary.

• Make available inpatient services which are accessible.

• Provide in person or virtual access to appropriate, locally based day treatment services.

ONGOING AND ANNUAL ASSESSMENTS

• Implement ongoing assessment of the needs of the patient population in compiling specialty and subspecialty network to ensure that access to behavioral health treatment will be available to all patients.
• Actively assess ease of access of referrals and reasons patients elect to opt out of network resources and share assessment results with purchasers of health care.

• Encourage contracts for behavioral health care that meet standards of recognized private sector accrediting bodies and share such information with patients.

• Ensure transparency of the flow and accountability for health care dollars, in order to assess what proportion of the enrollees' premium is paying for medical vs. non-medical costs.

• Encourage sustained, longitudinal research on patient outcomes including patient reported outcomes of the mental health services.

• Encourage the Massachusetts Bureau of Managed Care, the Health Care Access Bureau, and Office of Patient Protection to work with plans so that behavioral health care carve-outs generate validated utilization, outcome, and payment measures that can be used in ongoing assessments of carve-out functioning and make these measures available to the general public in compliance with federal and state parity statutes.

RECOGNITION OF THE VALUE OF MENTAL HEALTH SERVICES

• Recognize the value of subspecialty services such as psychotherapy, child psychiatry, complex case consultation, and needs of the seriously mentally ill.

• Recognize costs of living and of care delivery.

• Recognize the interrelationship of mental health with other medical illnesses such as substance use disorders.

• Offer transparent calculations of patients' out-of-pocket costs for mental health services.

• Offer a readily available, courteous claims resolution process.

• Facilitate timely provider network participation with the use of nationally or locally established uniform credentialing agreements.
(HP)

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
(Item 4 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society (MMS) continues to enthusiastically help and support the efforts of the Massachusetts Psychiatric Society and the Massachusetts Chapter, American Academy of Pediatrics with all payors to promote the ability of psychiatrists to render high-quality, appropriate medical psychiatric services to patients as well as recognize the on-going crisis in mental health care needs of infants, children, and adolescents. *(HP)*

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Independent Medical Review
The MMS will advocate for IME practices that protect injured and disabled patients' interests with appropriate safeguards such as best practices, model policies/procedures, and model state legislation. *(D)*

MMS House of Delegates, 12/10/22
(Item 1 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/9/23)

Out-of-Network Referrals
The MMS will advocate for a transparent process, including opportunity for an appeal, within alternative payment models and Medicare Advantage to protect physicians from punitive consequences for patient referrals out of network when those referrals are made in order to provide optimal and timely care for patients. *(D)*

The MMS supports protecting the patient's freedom to choose a physician and a health care delivery system, in order to preserve the patient-physician relationship. *(HP)*

MMS House of Delegates, 4/29/17
Reaffirmed MMS House of Delegates, 5/8/21

Physician-Patient Relationship
The MMS will oppose legislative efforts in Massachusetts and federally that interfere with, threaten, or impose or expect to impose an undue burden on a physician's ability to provide appropriate care consistent with good medical practice. *(D)*
MMS House of Delegates, 12/4/21

The MMS strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States. *(D)*

The MMS dedicates March 30 known as Doctor's Day, to the recognition of the basic principles of confidentiality and free speech in the doctor-patient relationship. *(D)*

MMS House of Delegates, 12/6/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The MMS will advocate that the Commonwealth of Massachusetts develop a plan with the MMS for Aliens with Special Status (legal aliens) to maintain their relationships with their current physicians. *(D)*

MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society will advocate that the Commonwealth of Massachusetts respect the primacy of the relationship between patients and their physicians and incorporate this as it develops health care delivery plans. *(D)*

The MMS opposes any legislation that would prevent permanent legal residents from accessing any health insurance options that are available to all American citizens. *(D)*

MMS House of Delegates, 12/5/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Physician Services
The Massachusetts Medical Society will do everything possible to empower physicians with the ability to independently make proper medical decisions for their patients and the public in general. *(D)*

MMS House of Delegates, 5/20/94
MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Physician-Controlled Offices, Ambulatory Surgery Centers, Free-Standing Imaging Centers, Determination of Need
The MMS will advocate to prevent hospital-based networks from using their market and contracting power to drive patients away from, disadvantage, or otherwise impede, physician-owned in-office and free-standing ancillary services, and the potential resultant flow of referrals to hospital-owned outpatient ancillary services. *(D)*

MMS House of Delegates, 12/5/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS will advocate for modification of the DON-related provisions of Massachusetts law and regulation in ways that will remove statutory impediments to the ability of physician-controlled offices, ambulatory surgery centers, and free-standing imaging centers to compete on the basis of cost and quality for the benefit of patients, physicians, and the health system as a whole. *(D)*

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

The MMS favors increased flexibility, decreased regulatory burdens, and, if feasible, repeal or revision of the Determination of Need (DON) law in Massachusetts in order to further the goals of health care reform. *(HP)*

The MMS will work to incorporate increased flexibility, decreased regulatory burdens, and, if feasible, repeal or revision of DON into its advocacy agenda with a report to the HOD on its progress at A-20. *(D)*

MMS House of Delegates, 5/4/19

Physician-Patient Privilege
The MMS will advocate to the relevant state and local bodies, and work with the AMA to advocate to the relevant national bodies, for the physician-patient privilege to be regulated according to the privacy protections in the Health Insurance Portability and Accountability Act of 1996 without regard to where care is received. *(D)*

MMS House of Delegates, 12/3/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Retail-Based Clinics
The MMS fully supports the AMA Code of Ethics statement that "as a member of this profession, a physician must recognize responsibility to patients first and foremost." *(HP)*

The MMS believes that store-based limited service clinics (SBLSCs) may challenge the physician-patient relationship. Therefore, it shall be a core mission of the MMS to help physicians maintain the highest professional standards in the face of emerging changes in the system of health care delivery, including potentially disruptive system changes such as the emergence of SBLSCs. *(HP)*

The MMS supports the position that continuity of patient care in the patient's medical home is a core value in primary care medicine. Insurance plans that impede continuity of medical care by providing incentives to patients to receive care at the SBLSC rather than the primary care physician's (PCP) practice may interfere with the patient/PCP relationship and continuity and quality of care. *(HP)*

The highest concern of the MMS is the quality, safety, and coordination of care provided to our patients. MMS therefore supports the following requirements of all SBLSC's in the Commonwealth:

a. Full compliance with existing state regulations without waivers of what constitutes a medical clinic as proffered by the Department of Public Health regarding the licensure of clinics.
b. Documentation of the visit should meet community standards in terms of completeness and legibility and be faxed or electronically sent to the patient's PCP office within 24 hours of the visit.
c. Patients should be referred to their PCP for follow up care. Patients not having PCPs who require follow up care should be referred to PCP's in the community accepting new patients.
d. The quality of care should be fully consistent with current quality standards.

(HP)

The MMS recommends research into the safety, efficacy, and cost-effectiveness of chronic disease management in the SBLSC setting as currently there are insufficient data to support the value of chronic disease management in the SBLC setting. *(D)*

The PCP and the medical home team should inform the patient about the PCP's team availability, office policies, and the benefits of the medical home for illness and health maintenance. *(HP)*

The MMS encourages PCPs to enhance their medical home's same day access availability for patients in support of sustaining the continuity of the physician-patient relationship. *(HP)*

The MMS, upon identifying significant areas of concern and potential improvement in patient services, shall urge the DPH to implement the advisory committee approved by the Public Health Council in January of 2008 and to include MMS representation. *(D)*

MMS House of Delegates, 11/15/08
Amended and Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The MMS will explore ways individual primary care clinicians can respond to retail-based clinics in their communities. *(D)*

MMS House of Delegates, 5/9/08
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society believes that retail-based clinics are not in the best long-term interest of patients or physicians in the Commonwealth, and will strongly work on a regulatory basis to assure that no waivers are granted and to hold the Massachusetts Department of Public Health accountable to its procedures. *(HP/D)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Reaffirmed for One Year Pending Review at A-22)
(Reaffirmed for One Year Pending Review at A-23)
(Reaffirmed for One Year Pending Review at A-24)

Primary Care
That the MMS supports legislation to foster a system of primary care that delivers equitable access to all, that incentivizes practice transformation toward a comprehensive model of care that significantly increases the funding for primary care to allow for and to encourage such transformation, and that allocates resources in an intentionally antiracist and just fashion, accounting for the severity of illness and social determinants of the population. *(HP)*

MMS House of Delegates, 5/21/22

The MMS supports the provision of high-quality primary care visits, including recommended screening, behavioral health integration, preventive care measures, care coordination, and other individualized care needs, for all populations. (*HP)*

The MMS supports the necessity of individualizing appropriate panel sizes and visit times for primary care office visits and preventive care visits in all populations, considering risk adjustments of patient variables, practice and organizational variables including available resources, the maturity of the panel, physician and clinic, and proxy indicators of panel size (burnout scores, documentation time, and chart closure rates). *(HP)*

The MMS recognizes that ideal panel size and visit times should take into consideration a variety of factors, including existing measures, care coordination, and other individualized care needs and also consider the impact of multiple modalities of telehealth including asynchronous care provided through a secure patient portal and the necessary time spent with the patient to meet internal and external quality and performance measures and support equitable care. *(HP)*

The MMS will disseminate policy related to individualized appropriate panel sizes and visit times to relevant stakeholders including large medical groups and hospital-affiliated practices. *(D)*

MMS House of Delegates, 5/21/22

Scientifically Unproven Risks

The Massachusetts Medical Society strongly opposes any legislation or regulation requiring providers to warn patients about scientifically unproven risks as a condition for performing a procedure or providing medical care. *(HP)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Team-Based Health Care

The MMS considers "team-based health care" as the provision of health care services by a physician-led team of at least two health care professionals who work collaboratively with each other and the patient and family to accomplish shared goals within and across settings to achieve coordinated, high-quality, patient-centered care. *(HP)*

The MMS will advocate that the physician leader of a physician-led inter-professional health care team be empowered to perform the full range of medical interventions that she or he is trained to perform. *(D)*

The MMS will advocate that with physician oversight, all members of an inter-professional health care team be enabled to maximize their full educational capacity in order to effectively provide quality patient care. *(D)*

The MMS adopts the following principles to guide physician leaders of health care teams:

- Focus the team on patient and family-centered care.
- Make clear the team's mission, vision, and values.
- Direct and/or engage in collaboration with team members on patient care.
- Be accountable for clinical care, quality improvement, efficiency of care, and continuing education.
- Foster a respectful team culture and encourage team members to contribute the full extent of their professional insights, information, and resources.
- Encourage adherence to best practice protocols that team members are expected to follow.
- Manage care transitions by the team so that they are efficient and effective, and transparent to the patient and family.
- Promote clinical collaboration, coordination, and communication within the team to ensure efficient, quality care is provided to the patient and that knowledge and expertise from team members is shared and utilized.
- Support open communication among and between the patient and family and the team members to enhance quality patient care and to define the roles and responsibilities of the team members that they encounter within the specific team, group, or network.
- Facilitate the work of the team and be responsible for reviewing team members' clinical work and documentation.
- Review measures of "population health" periodically when the team is responsible for the care of a defined group.

(HP)

The MMS encourages independent physician practices and small group practices to consider opportunities to form health care teams, such as through independent practice associations, virtual networks or other networks of independent providers. *(D)*

The MMS will monitor the work that other organizations are doing around innovative payment mechanisms that appropriately compensate the physician and/or team for team-based health care. *(D)*

The MMS will advocate that the structure, governance, and compensation of the team should be aligned to optimize the performance of the team leader and team members and adopt the following policy:

The MMS endorses the principle that the appropriate ratio of physician to non-physician extender practitioners should be determined by physicians at the practice level, consistent with good medical practice, and state law where relevant, taking into consideration the physician's specialty, physician's panel size, and disease burden of the patient case mix. *(HP)*

MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Telemedicine

The MMS will advocate that whether a service can be appropriately provided through telemedicine is a clinical decision that should be made by a physician caring for the patient. *(D)*

The MMS will advocate for adequate resources, including universal broadband, and removal of barriers for vulnerable populations so that they can avail themselves of the full benefit of telemedicine care. *(D)*

The MMS will advocate for payment parity for care delivered via telemedicine, audio or audio-visual, independent of the time frame by which the telemedicine visit may be followed by an in-office visit. *(D)*

The MMS will monitor the benefits and complexities of alternative payment arrangements for telemedicine. *(D)*

The MMS will work with appropriate stakeholders to monitor the benefits and complexities of national telemedicine licensure and the matter of individuals in other states who want to be seen but do not yet have a relationship with the physician. *(D)*

The MMS will advocate that the usage of telemedicine be expanded to include special circumstances that make the patient's travel to the doctor's office difficult or dangerous. These circumstances would include, for example, weather events, childcare or elder care responsibility, lack of transportation, frailty, limited ability to ambulate, a contagious disease, and other scenarios. *(D)*

The MMS will advocate that prior authorization requirements will not be imposed on telemedicine visits if they are not imposed on in-person visits. *(D)*

The MMS will advocate that insurers (including MassHealth and Medicare) cover interpreter services for patients with limited English proficiency and for those who are deaf or hard of hearing. *(D)*

The MMS will advocate that insurers be prevented from imposing copay requirements for telehealth services for at least 90 days past the Governor's declared state of emergency due to all present and future pandemics. *(D)*

The MMS will develop educational programs to advance best practices in telemedicine in the Commonwealth. *(D)*

The MMS will explore appropriate telemedicine collaborations and coalitions, identify key areas for growth, prioritize resources, and develop a plan to explore new opportunities consistent with MMS mission. *(D)*

The MMS will work through coalitions to help patients better understand telemedicine technology and how to interact with it to promote safe, high-quality care. *(D)*

MMS House of Delegates, 5/8/21
(Items 4, 6, and 12 of Original Auto-Sunset: Time-Limited Directives Completed 5/21/22)

The MMS will advocate for a common regional reciprocal regulatory construct whereby each northeast state would allow Massachusetts licensed physicians with an existing clinical relationship, as defined by the Massachusetts Board of

Registration in Medicine, to provide telemedicine to patients located in other states without having to obtain a medical license in those states. *(D)*

The MMS will support reforms to the Interstate Medical Licensure Compact, including to its fee structure, to better support physicians whose limited interstate telemedicine practice may not justify paying full licensure fees. *(D)*

MMS House of Delegates, 5/8/21

The MMS will advocate for legislative and regulatory efforts to expand access to care for patients of Massachusetts licensed physicians, who wish to use telemedicine where appropriate to minimize the barriers to care for their patients and that can be delivered to the patient at home or wherever the patient may need care. *(D)*

The MMS will advocate for continuing efforts to evaluate the efficacy, safety, and applicability of telemedicine. *(D)*

The MMS will continue to advocate for parity in payment for telemedicine services that are equivalent to in-person services, when they are medically appropriate. *(D)*

MMS House of Delegates, 4/29/17

The MMS will advocate for adequate reimbursement for services submitted under the existing telemedicine codes such as telephone consultations, chart reviews, and physician-to-patient communication including telephone, videoconferencing, and secure email/patient gateway communication — as long as such actions are documented in appropriate records. *(D)*

MMS House of Delegates, 12/3/16
(Reaffirmed for 1 Year Pending Review at A-24)

The Massachusetts Medical Society, with other interested parties, including the American Medical Association, continue to encourage the Centers for Medicare and Medicaid Services of the Department of Health and Human Services and all other payors to reimburse physicians for telemedicine services beyond the rural and underserved areas. *(HP)*

MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

The Committee on Information Technology shall continue to monitor and study developments in telemedicine practices. *(D)*

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Telemedicine is defined as the use of telecommunications technologies over distance (including, but not limited to, telephone, wire, facsimile machine, computers, satellites, fiber optics, lasers, television, robotics, virtual imaging) in the application of health care delivery, diagnosis, treatment, triage, information, and data transfer, consultation and medical education among patients, physicians, other providers, organizations, and governments. *(HP)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The Massachusetts Medical Society affirms that any physician practicing telemedicine with a patient in Massachusetts should possess a full and unrestricted license in Massachusetts. *(HP)*

MMS House of Delegates, 11/21/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Treatment Variations
The Massachusetts Medical Society will cooperate with other institutions and agencies who are committed to explore the validity, causes, meaning, and long- term significance of treatment variations in surgical and medical practices as identified in studies using population based data. *(HP)*

MMS Council, 5/20/89
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Workers' Compensation Coverage
The MMS will advocate for an improved, equitable workers' compensation system, which includes sustainable, increased reimbursement for physicians and all other providers taking care of injured/ill workers, and which includes necessary reforms and innovations to incentivize high-quality medical care. *(D)*

The MMS will work with community stakeholders and organizations (such as the New England College of Occupational and Environmental Medicine, among others) to promote innovative payment solutions that will protect the workforce of Massachusetts and ensure that these workers receive timely care. *(D)*

MMS House of Delegates, 5/21/22

The Massachusetts Medical Society (MMS) encourages maximum workplace safety for all workers. *(HP)*

The MMS supports efforts to increase access to workers' compensation coverage for all workers, including immigrant workers, as provided for by Massachusetts law. *(HP)*

The MMS promotes awareness among Massachusetts health care providers of workers' compensation coverage for immigrant workers. *(HP)*

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20
(Item 3 of Original): Amended and Reaffirmed MMS House of Delegates 12/5/20

HEALTH EDUCATION

Student Health
The MMS encourages local communities to provide age-appropriate comprehensive health education to students that incorporates information on the prevention of STIs, including HIV. *(D)*

MMS House of Delegates, 5/14/04
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 4/28/18
Reaffirmed MMS House of Delegates, 5/4/19

Translation of Patient Education Material
The Massachusetts Medical Society (MMS) will provide for the professional translation of patient education materials developed by the Society in one or more non-English versions, in order to meet significant unmet community needs. *(D)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

HEALTH INSURANCE/MANAGED CARE PLANS

Administrative Costs
The Massachusetts Medical Society believes that, unless otherwise required by law, physicians should be paid a reasonable fee for the preparation of reports, copying, and postage when asked to provide information to third parties. *(HP)*

Physicians shall continue to comply with the requirement to provide copies of medical records to the patient according to state law. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Antitrust/Anticompetitive Markets
The Massachusetts Medical Society adopts the following adapted from an American Medical Association directive:

> That the Massachusetts Medical Society work locally and with national stakeholders to monitor and oppose consolidation in the health insurance industry, given that it may result in anticompetitive markets. *(D)*
> *MMS House of Delegates, 5/7/16*
> *Reaffirmed MMS House of Delegates, 5/13/23*

The Massachusetts Medical Society (MMS) supports state and federal solutions to antitrust issues; and the MMS will continue efforts aimed at easing practice constraints on physicians. *(HP)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society supports legislation in the United States Congress that would allow physicians as a group to negotiate without fear of antitrust violation with payers, such as insurance companies, HMOs, and managed care companies on the terms of physicians' contracts, such as payment rates, clinical decision-making and administrative responsibilities. *(HP)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Breast Imaging
The MMS will advocate that diagnostic breast imaging, including breast MRI and supplemental screening, be covered without copayment, coinsurance, prior authorization, deductible, or dollar limit provisions. *(D)*
MMS House of Delegates, 12/4/21

Coverage Decisions
The Massachusetts Medical Society adopts the following Principles for Health Plan Coverage Decisions:

I. Health plan processes for designing and determining health plan coverage decisions should be:

- Evidence based
- Transparent
- Participatory
- Equitable and Consistent
- Sensitive to Value
- Compassionate

II. Health plan processes for designing and determining health plan coverage decisions should:

a. Assure that the health plan's clinical policies and treatment approval decisions are responsive to patient concerns.

   i. Physicians and patients should have access to the clinical guidelines for all health plans in which they participate via websites and/or written materials.
   ii. All clinical policies should be based on the best available evidence.

b. Establish physician advisory groups through which physicians participating in the plan's network can provide input into the health plan's policies affecting coverage decisions.

   i. Health plans should be transparent as to who serves on the advisory group.
   ii. Advisory groups should include practicing physicians with the appropriate expertise.

c. Include health plan members in decision-making at the appropriate organizational level regarding policies and processes that affect patient care and allocation of clinical resources.
   i. Provide employers, health plan members and participating physicians with the criteria and process used for determining when new technologies and procedures become a covered benefit.
   ii. Explicitly describe those services it will not currently cover because they are deemed to be "experimental."

d. Be based on best available scientific evidence, in the context of treatment expense.

e. Involve physicians and health plan members in appeals regarding treatment authorizations. Ensure physicians have the right to appeal adverse coverage decisions. Health plans should have in place systems to review and process physician appeals when appropriate.

f. Respond to requests for prior authorization of a non-emergency service, upon receipt of complete information, within a reasonably pre-determined time frame.

g. Identify information that health plan members want and need regarding the plan's process for making coverage decisions.

h. Provide easy access for all stakeholders to information about the health plan's decision-making processes in language that is easily comprehensible.

(HP)

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

Fee Schedules

The Massachusetts Medical Society will advocate that the equation that third-party payers use to calculate the fee schedule include the most recent economic data and the cost of delivering care at the time of contracting in the geographic area where the physician is practicing. *(D)*

(Approved MMS Board of Trustees, 10/11/17)
Accepted MMS House of Delegates, 12/2/17

The MMS will advocate for and affirm that the third-party payer shall release to the participating physician practice said practice's fee schedule within two business days of a written or documented phone request. *(D)*

MMS House of Delegates, 12/3/16
Reaffirmed MMS House of Delegates, 5/13/23

Financial Incentives
The Massachusetts Medical Society, in addition to its policies on Financial Incentives and policy document entitled Ethical Standards in Managed Care, will pursue federal and state legislative remedies which will add more safeguards to limit financial risk arrangements that might impinge on the quality of patient care and the financial viability of physician practices. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

It shall be the policy of the MMS that health plans should not establish financial incentives or quotas that interfere with clinical judgment such as limiting diagnostic tests, services, referrals, or access to care. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Health Care Expenditure Accounts
The Massachusetts Medical Society supports mechanisms for minimizing patient out-of-pocket health care costs, including through the use of tax-exempt patient health care expenditure accounts. *(HP)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Health Insurance
The Massachusetts Medical Society supports an individual's right to select, purchase, and own his/her health insurance and to receive similar tax treatment for individually purchased insurance as for employer purchased coverage. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

High-Deductible Health Plans
The Massachusetts Medical Society will advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments, so that insurers will pay the entire usual fee for these codes without triggering any deductible payment by the patient. *(D)*

MMS House of Delegates, 12/1/18

That, in the face of any possible changes in federal laws regarding health insurance coverage, the MMS will support and advocate for continuation of the state individual mandate to purchase health insurance, the state's Minimum Creditable Coverage standards, and the state Connector Care Program. *(D)*

The MMS will support and advocate for evaluation of value-based cost sharing measures for high-deductible health plans and patients' out-of-pocket costs. *(D)*

The MMS will support and advocate that the Commonwealth assess the impact of cost-sharing on access to care, health outcomes, and medical debt for patients. *(D)*

The MMS will support and advocate that the Commonwealth assess the impact of cost sharing on provider's due to patients' inability to pay when there is cost-sharing. *(D)*

The MMS will continue to be a strong voice of concern about the adverse effects of cost-sharing on patient health. *(HP)*

(Approved MMS Board of Trustees, 2/7/18)
Accepted MMS House of Delegates, 4/28/18

Informing Patients Regarding Health Care Costs
The MMS takes the position that those who set rates of reimbursement are responsible for informing patients of their anticipated health care costs. *(HP)*
The MMS will actively oppose any requirements that a physician inform patients of their anticipated total health care costs. *(D)*

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

Insurance Company Health Surveys
The Massachusetts Medical Society (MMS) opposes the collection of sensitive mental health information by insurance companies that is requested directly from patients. *(D)*

The MMS will take all appropriate action to prevent insurance companies' use of personal health surveys as a factor in determining provider compensation or patient coverage and eligibility. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Managed Care Resources & Education
The MMS adopts the following principles:
1. All consumer information from insurers should be made available through a wide array of media, including but not limited to print (e.g., brochures and advertisements) and internet-based materials.
2. Consumer information should be presented in a clear and concise manner and should include additional levels of information at the consumer's preference and based on the diverse composition of our communities.
3. Examples and anecdotal information should be provided in consumer information materials, as appropriate, to make the information as relevant for the consumer as possible and based on the diverse composition of our communities.
4. Consumers should be active participants in the development of the resources (e.g., pre- and post-test) to provide insurers with feedback on the level and quality of the information.
5. Consumer information should be made available in a wide variety of languages and based on the diverse composition of our communities.

(HP)

MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society will review existing state statutes, state regulations and policies concerning timely payment by third party payers, disseminate this information to the membership and, where appropriate, file legislation to enhance timely payment of claims including the provision of penalties and interest. *(D)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Medicare/Low-Vision Aids
The MMS will advocate for legislative and regulatory actions promoting insurance coverage for low vision aids for patients with low vision as defined by Medicare. *(D)*

MMS House of Delegates, 5/4/19
(Item 2 of Original: Auto-Sunset, Time-Limited Directive Completed: MMS House of Delegates, 12/5/20)

Radiology Co-Payments
The MMS will continue to monitor the impact of health plans' use of co-payments for radiology studies that could limit patient access, and when appropriate, advocate for modified co-payments when they are in the best interest of patients. *(HP)*

MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Value-Based Insurance Design
The MMS will monitor third-party payers who use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. *(D)*

The MMS supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians should be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. Recognizing the development of networks, and the need to keep patients in network, VBID should not restrict the necessary patient care including the ability to have second and third opinions.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.

(HP)

MMS House of Delegates, 12/7/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

HEALTH SYSTEM REFORM

Fee-for-Service
The MMS recognizes that fee-for-service and private practice medicine can be efficient, ethical, and high-quality medical care, with a long tradition of patient-centered care and cost-effective care which keeps patients at the center of treatment decisions. *(HP)*

The MMS, when advocating for system reform, enthusiastically advocates for preserving the viability of a private practice option, for the benefit of patients and our members. *(D)*

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

Health Care Costs
The MMS will collaborate with multi-stakeholders to define and measure primary care spend in Massachusetts to determine future investments in primary care services. *(D)*

(Approved MMS Board of Trustees, 8/28/19)
Accepted MMS House of Delegates, 12/7/19

The MMS adopts principles for spending of finite health care dollars that include, but are not limited to, the following:

1. Recommendations about how best to spend limited health care dollars should be made based on the best available evidence regarding cost-effective application of resources as reviewed by a committee of representative physicians, residents of Massachusetts, and others with the expertise necessary to make these recommendations.
2. The committee's recommendations should be free from any financial conflict of interest or political influence.
3. The plan for development of recommendations must include a robust feedback process that includes frequent review of all guidelines and a timely, individual grievance process.

4. All deliberations of the committee reviewing and developing the recommendations should be transparent and open to public scrutiny.
5. In order to promote physicians' adoption of guideline recommendations designed to minimize defensive medicine, maintain quality, and reduce health care costs, malpractice reform is necessary.

(HP)

MMS House of Delegates, 12/4/10
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society (MMS) acknowledges the unsustainable escalation of health care costs. *(HP)*

The MMS will partner with other stakeholders to address system-wide mechanisms to control the forces responsible for the escalation in health care costs. These include among others:

a. improving the market structure for medical services through transparency of price and outcomes
b. encouraging the development of guidelines in diagnosis and treatment of conditions where evidence-based approaches are not yet available
c. suggesting insurance reform mechanisms to reduce consumer purchase of marginally-useful service, likely through higher copayment for such services

(D)

The MMS encourages a pluralistic compensation system to include fee-for-service, salary, capitation, and limited pilot studies that utilize global payments system. *(D)*

The MMS acknowledges that the fee-for-service system has positive value in the payment for medical services. *(HP)*

The MMS will continue its strong support for medical liability reform, and implementation of early resolution programs, to reduce the waste resulting from over utilization resulting from defensive medicine. *(HP)*

MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

The MMS will advocate that local health plans reimburse cognitive services at a level commensurate with the expertise and time required for these services. *(D)*

The MMS maintains opposition to the federal budget neutrality of the Medicare Physician Fee Schedule, which constrains physician payments to reduce overall national health care expenditures. *(HP)*

The MMS will periodically explore and evaluate the progress of alternative payment models and methodologies, as well as opportunities for physician participation in these model programs, with an annual report to the membership. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 1, 2, 5, and 6 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Health Care Is a Basic Human Right

The Massachusetts Medical Society asserts that enjoyment of the highest attainable standard of health, in all its dimensions, including health care, is a basic human right. *(HP)*

The provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. *(HP)*

MMS House of Delegates, 5/4/19
Reaffirmed MMS House of Delegates, 12/10/22

Ideal Payer System

The Massachusetts Medical Society (MMS) defines an ideal payer system and the definition encompasses goals that include:

- universal coverage of population;
- coverage of preexisting conditions;
- accessibility to everyone regardless of location or background;
- portability for all medically necessary services; and

The MMS definition of an ideal payer system encompasses comprehensive services that include:

- acute and chronic illness care;
- prevention of disease and disability by risk assessment and education to change behaviors that may lead to disease or injury, early disease detection and treatment: to prevent, diminish, compress, and delay its disablements;
- rehabilitation of disabled persons: to improve their function for work and living;
- immunization;
- counseling and other behavior health support;
- unimpeded access to appropriate specialty and subspecialty care; and

The MMS definition of an ideal payer system encompasses qualities, that include:

- efficiency/cost-effectiveness;
- equity/fairness, convenience and satisfying;
- maximal patient and physician involvement and engagement, including, choice, mutual decision-making, and respect;
- use of appropriate technologies, scientifically assessed for the needs of patients;
- continuous improvement efforts for better health care;
- outcomes through: practitioner education, at the undergraduate, graduate, and continuing medical education levels;
- research;
- reorganization of processes of care;
- professional self-management, internal to the practice;
- voluntary participation of physicians and patients;
- maintain freedom of physicians to contract directly with their patients;
- individuals retain right to establish medical saving accounts and to purchase catastrophic health insurance from insurer's of their choice
- maintain freedom of entry into the health insurance market and attention given and care delivery changes made based on outcome measurement and patient and physician experience surveys; and

The MMS definition of an ideal payer system encompasses characteristics for payment of services and insurance, that include:

- simplicity
  - uniform administrative criteria for eligibility and billing,
  - single forms,
  - single open formulary;
- accountability;
- consistency in benefit coverage limitations related to scientific evidence and expert opinion;
- timeliness;
- responsiveness: correction of defects; and
- appropriate funding

(HP)

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Patient Protection
The Massachusetts Medical Society in its ongoing discussions on health system reform with Congress, the Administration and the American Medical Association, will continue to assign first priority to responding to the needs of the patients we serve. *(HP)*

MMS House of Delegates, 11/17/95
Reaffirmed MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Principles for Health Care Reform
The Massachusetts Medical Society adopts as amended the Principles for Health System Reform policy adopted at A-11 to reads as follows:

The Massachusetts Medical Society adopts the following Principles for Health Care Reform:

1. *Physician leadership*. Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.

2. *One size will not fit all*. One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.

3. *Deliberate and careful*. Efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.

4. *Fee-for-service payments have a role*. While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments should be a component of any payment system.

5. *Infrastructure support*. Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.

6. *Proper risk adjustment*. In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.

7. *Transparency*. There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.

8. *Proper measurements and good data*. Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.

9. *Patient expectations*. Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and

payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

10. *Patient incentives*. Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.

11. *Benefit design*. Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.

12. *Professional liability reform*. Defensive medicine is not in the patient's best interest and increases the cost of healthcare. A payment model where physicians have the incentive to do less, but combined with an environment where patients request more, may lead to increased litigation as an inevitable outcome unless there is effective professional liability reform.

13. *Antitrust reform*. As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state and federal legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.

14. *Administrative simplification*. Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians should be protected from undue administrative burdens or should be appropriately compensated for it.

15. *The incentives to transition*. In order to transition to a new model, incentives must be predominantly positive.

16. *Planning must be flexible*. Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.

17. *Primary care physician.* All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.

18. *Patient access.* Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities.

(HP)

MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 5/4/19

The Massachusetts Medical Society will advocate with insurers and other stakeholders to make copayments for services rendered at retail-based clinics at least equivalent to an office visit. *(D)*

MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Universal Access

The MMS supports and will advocate for universal access to equitable, comprehensive, affordable, high-quality, administratively streamlined health care through a national health program, as well as through legislation at the state level and will continue to explore and evaluate payment structures that may be able to achieve these goals. *(HP/D)*

MMS House of Delegates, 5/13/23

The Massachusetts Medical Society supports comprehensive health coverage that provides universal access to equitable, high-quality, continuous, affordable health care, and is open to supporting any proposal that achieves this fundamental universal coverage goal. *(HP)*

The Massachusetts Medical Society will take a leadership role in advocating for comprehensive health coverage that provides universal access to equitable, high-quality, continuous, affordable health care, and oppose proposals that undermine these principles. *(D)*

MMS House of Delegates, 12/5/20

The Massachusetts Medical Society supports a system for health insurance coverage that allows for universal access to quality, equitable, affordable coverage. *(HP)*

The Massachusetts Medical Society take a leadership role in advocating for health insurance coverage that allows for universal access to quality, equitable, affordable coverage. *(D)*

MMS House of Delegates, 12/7/19
(Item 3 of Original: Sunset, Time-Limited Directive Completed, MMS House of Delegates, 12/5/20)

HOSPITALS

Compensation/Physician Services

The Massachusetts Medical Society believes hospitals should provide mutually agreeable, negotiated compensation to physicians for the services physicians provide to hospitals. *(HP)*

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Credentialing

The MMS will work with the Massachusetts Health and Hospital Association to develop ways to simplify the hospital credentialing process for physicians and centralize hospital credentialing. *(D)*

MMS House of Delegates, 11/15/08, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The Massachusetts Medical Society (MMS) will continue to promote the use of a uniform application form for credentialing and re-credentialing to all Massachusetts hospitals, other health care facilities, managed care organizations**,** and other health care insurers**.** *(D)*

MMS House of Delegates, 5/13/05
Item 1 of Original: Reaffirmed MMS House of Delegates, 5/19/12
(Item 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/4/19

The Massachusetts Medical Society (MMS) shall work with all concerned parties to advocate for uniform minimum evidence-based standards for credentialing physicians. *(D)*

The MMS encourages uniformity for the process, timing, transparency, and standards for credentialing with health care institutions and managed care organizations. *(HP)*

The Massachusetts Medical Society will advocate for review of all credentialing applications and changing any invasive or stigmatizing language around mental health. *(D)*

MMS House of Delegates, 5/11/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08
(Item 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The MMS supports the concept that credentialing of physicians by hospitals, managed care organizations, and other health care facilities include professionalism, and the evaluation of the individual's training and experience in the light of nationally accepted clinical criteria. *(HP)*

The MMS will continue to work with state regulatory agencies to assure that any state imposed credentialing standards which limit the ability of licensed Massachusetts physicians to practice at any licensed facility are developed with evidenced based standards developed by physicians. *(D)*

In any case when new regulations establishing minimum clinical standards are proposed by state agencies, the MMS may establish a representative working group, coordinated by an established MMS Committee, to help formulate the MMS response. *(D)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Disaster Planning
The Massachusetts Medical Society adopts the following adapted from American Medical Association policy:

That the MMS:

1. Encourage appropriate stakeholders to examine the barriers and facilitators that medical staffs encounter following a natural or other disaster
2. Encourage hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff response during a natural or other disaster
3. Update the MMS Model Medical Staff Bylaws to include such policy recommendations

(D)

MMS House of Delegates, 4/28/18

Hospital and Health Care Facility Closings
The Massachusetts Medical Society adopts the following principles regarding Health Care Facility Closure—Physician Credentialing Records:

1. *Governing Body to Make Arrangements*
   The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility. The governing body shall send notification of the impending closure to all those physicians credentialed at that facility at least 30 days prior to the date of closure.

2. *Transfer to New or Succeeding Custodian*
   Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

3. *Documentation of Physician Credentials*
   The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

4. *Maintenance and Retention*
   Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records. The records shall be maintained for a period of at least two years from the date the facility closes.

5. *Access and Fees*
   The new custodian of the records shall provide timely access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records.

(HP)

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

That the Massachusetts Medical Society amend its policy on Hospital and Health Care Facilities Closings, reaffirmed at A-16, to read as follows:

The MMS will work with appropriate state bodies to assure that whenever there is either a threatened or an actual hospital closure, a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship; this process should also assure that adequate capacity exists or can be developed in the immediate area surrounding the hospital closure, including engagement of independent health resources and providers in the service area, to provide for the citizens of that area; and that whenever there is a threatened or actual hospital closure, restrictive covenants and financial barriers, which prevent the movement of physicians and their patients to surrounding hospitals, should be re-examined and waived for an appropriate period, so continuity of care is preserved. *(D)*

The MMS will work with appropriate interested parties to study new models of oversight and health care planning that include such items as:
(A) Mandatory concurrent, ongoing financial reporting by health care organizations to an appropriate oversight entity to facilitate early identification of any hospital in financial distress;
(B) A process to intervene when such financial instability is detected; and
(C) A process to assure adequate funding to maintain the health care delivery system and to insure access to health care for the citizens of Massachusetts. *(D)*

The MMS will proactively offer support to physicians, residents and fellows, patients, and civic leaders affected by facility closures, via provision of transition information, resources, and effective, actionable advocacy. *(D)*

That in urgent or extreme circumstances related to threatened or actual hospital closure, or reduction in services that will likely result in diminished access to care or quality of care of a community, the MMS will proactively offer support to physicians, patients, and civic leaders affected by such imminent circumstances, via provision of information and effective, actionable advocacy. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Items 1-3 and 5-6 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Hospitalists
The Massachusetts Medical Society endorses the following principles developed by the American Medical Association, American Hospital Association, the Joint Commission, the Centers for Medicare and Medicaid Services, and the Society of Hospital Medicine:

Principles for a Sustainable and Successful Hospitalist Program

Vision
1. Seek to involve and address the needs of all key stakeholders in designing and implementing a hospitalist program. These stakeholders include patients, the medical staff, other clinical professionals, hospital administration, and the hospitalists.
    - Patients: A hospitalist program introduces a new "player" into the healthcare system. Patients expect to have their primary care physician (PCP) treating them when they are admitted to the hospital. As such, it is important that all parties (the PCP, the hospital, and the hospitalist) develop communication programs that explain the hospitalist model. Brochures and newsletters are tools that can be used to improve communications. Also, it is important to measure patient satisfaction. When evaluating patient satisfaction with hospitalists, recognize that there are factors that can negatively impact these ratings — specifically, the likelihood that the patients have been admitted through the emergency department and they are expecting care from their PCPs.
    - Medical Staff: Hospitalist programs can provide a significant service to other physicians at the hospital. Specifically, 1) PCPs may not want to do emergency call at the hospital; 2) PCPs may decide that doing inpatient

care is not cost effective and/or it disrupts their office-based practice; 3) surgeons and specialists may seek hospitalist support in handling more routine inpatient care and/or in co-managing their patients; and 4) emergency physicians and hospitalists have to work together to treat and admit patients. As such, it can be helpful to involve the medical staff in the design, implementation, and review of the hospitalist program. A "Hospitalist Advisory Committee" may be a useful vehicle for addressing these issues. A hospitalist program may want to implement satisfaction surveys, to determine how the hospitalists are perceived by other members of the medical staff. Also, hospitalists should be involved in medical staff activities and in its leadership.

- Other Clinical Professionals: The care and treatment of medical inpatients requires coordination among all of the clinical professionals in the
  hospital — nurses, case managers, social workers, physical therapists, etc. These professionals also can play a role in the development and implementation of a hospitalist program. If nurse turnover is an issue at the hospital, hospitalists may play a role in addressing nurse satisfaction.
- Hospital Administration: Hospital administrators often define the goals and provide the financial support for hospitalist programs. By definition, they will play a key role in designing and monitoring the hospitalist program.
- Hospitalists: Hospitalists need to be treated as professional colleagues and as equal, legitimate members of the medical staff, not as contractors hired to do the work that other physicians do not want to do. A successful hospitalist program will acknowledge the importance of physician satisfaction and the risks and dangers to the program of the potential burnout of hospitalists.

NOTE: In developing and implementing the goals of the hospitalist program, a balance must be sought among the interests of the various stakeholders. Issues may arise if it appears that the interests of one group of stakeholders (i.e., the hospital administrators, the medical staff, other clinical staff, the hospitalists) is overemphasized.

2. Promote a hospitalist model that focuses on team-based inpatient care. The delivery of inpatient medical care often suffers from coordination problems. During the hospital stay, patients and their family members may have to sort through information, diagnoses, and treatments from an attending physician, consulting specialists, nurses, residents, therapists, social workers, case managers and others. Effective inpatient care is a "team sport." Since hospitalists spend virtually all of their time in the hospital, there is a unique opportunity for hospitalists and other clinical professionals to develop shared goals, mutual respect, and improved communication. A team-based model of inpatient care can result in superior coordination of care and patient outcomes.

3. Recognize the potential of hospitalists to help address vital strategic issues for the hospital. These concerns include financial pressures; staffing shortages and dissatisfaction; quality and patient safety; new technologies; employer and consumer demands for performance metrics; capacity constraints; and increased competition. Many physicians are no longer able or willing to serve on hospital committees or play a leadership role for the medical staff. Hospitalists have the potential to step in and help address these key issues for the following reasons:
   - Hospitalists spend the majority of their time in the inpatient environment, making them familiar with hospital systems, policies, services, departments, and staff.
   - Hospitalists are inpatient experts who possess clinical credibility when addressing key issues regarding the inpatient environment.
   - Many hospitalists are hospital employees who can understand the tradeoffs involved in balancing the needs of the institution with those of the medical staff, the referral sources, and the patients. Even hospitalists who are not employed by the hospital have an intimate knowledge of the issues that the hospital is facing and are invested in finding solutions to these problems.

4. Anticipate the ongoing evolution in the scope of hospitalist practice. As hospitalist programs mature within their organizations, often the hospital leadership and medical staff seek to expand the role and responsibilities of hospitalists. All hospitalists should be prepared for an evolving set of responsibilities that may expand beyond the traditional scope of their training background. If hospitalists agree to assume broader responsibilities, they may need to acquire additional skills and expertise. That being said, the hospital leadership and medical staff should be careful not to overburden the hospitalists or mandate new responsibilities for the hospitalists. A balance must be sought that addresses a reasonable workload, the skills of the hospitalists, and the needs of the institution.

Organization/Structure

5. Choose a hospitalist leader with the right skills and experience. Selecting the right leader is fundamental to a successful hospitalist practice. These individuals are hard to find. They must be excellent clinically and have superb communications skills. Although they need to be assertive, they must also be good listeners. Political skills are essential to navigate medical staff, departmental, and administrative issues. An understanding of and appreciation for

practice economics will help to ensure that revenue is optimized and benefits to the financial supporters of the program are tracked.

6. Build structure and incentives with the goal of creating an "ownership" mentality for hospitalists in the practice. Hospitalists need to think of themselves as owners of their practice, even if they are employees or contractors of a hospital or multispecialty clinic. An employee or "shift" mentality may lead to hospitalists unwilling to step in to help out other physicians (both hospitalists and non-hospitalists) or to stay until the work is done. They may feel like it is someone else's problem to address the financial status of the hospitalist program. There are many ways that a hospitalist program can create this sense of ownership, but perhaps the most effective is to implement a compensation system that rewards performance, including productivity and clinical quality. The goal of the compensation model and incentives should be to connect physician incomes with the economic health and/or clinical quality of the practice. Ongoing training and education with regular audits for proper documentation, billing, and coding are essential to maximizing reimbursement for the work that has been done and to maintaining fiscal viability of any program. Physicians who are in a hospital employee or "guaranteed salary" practice model may be particularly vulnerable to neglecting proper billing and coding since this might not affect their individual income, but this has tremendous impact on the financial health of both the program and the hospital.

7. Assure that the hospitalist practice has the necessary tools and support to achieve their objectives: Like any physician practice, a hospitalist program needs adequate administrative support to help with billing, performance reporting, tracking patient census and volumes, information exchange with PCPs, etc. The practice may want to consider purchasing one of the hospitalist software products available in the marketplace. Also, hospital administration should assure that the hospitalists have access to other hospital departments such as information systems, finance, and utilization reporting. Finally, the medical director of the hospitalist program needs sufficient non-clinical time to address administrative and leadership issues.

Relationships/Communications

8. Use of hospitalist program should be optional for referring physicians and should never be mandated, especially not by hospital administration or by third party payers. Success of a hospitalist program requires the support and "buy-in" of all of the stakeholders involved in its use, particularly the referring physicians and the patients. Under no circumstances should a PCP be required to refer patients to a hospitalist program in lieu of caring for that patient him/herself. Likewise, no third-party payors should require patients be followed by a hospitalist rather than their PCPs they have chosen, unless the PCP is not contracted with the payor or the facility. PCPs may choose to forgo rounding on their own hospitalized patients and this, in turn, may require those patients to see a different physician, but those patients could usually then choose a different physician that still makes rounds if this is their preference.

9. Develop a process for identifying, addressing, and resolving issues between hospitalists and the medical staff. Whenever a hospitalist program is introduced at a hospital, a range of new "practice" issues arise with the medical staff. Examples include: 1) the roles of the hospitalist and the emergency physician; 2) the role of the hospitalist in providing emergency department call; 3) the responsibilities of the hospitalist and the surgeon when co-managing a patient; 4) the responsibilities of the hospitalist and the medical specialist when co-managing a patient; 5) the availability of specialists for consultations; 6) the hospitalist's choice of consultants; and 7) the timeliness of hospitalist communications to PCPs; etc. Physician leadership at the hospital (e.g., a Chief Medical Officer or Vice President – Medical Affairs) can play a vital role in identifying and resolving these issues. Some hospitals have used a "Hospitalist Advisory Committee" to address the issues.

10. Assure hospitalists and community physicians share accountability for the patient and the exchange of patient information in a timely manner. Community physicians (typically PCPs) refer their patients to hospitalists for inpatient care. This creates a discontinuity of care and both parties must assume a level of accountability. At admission, the PCP must be sure that the hospitalist receives all information need to treat the patient. At discharge, the hospitalist must dictate discharge notes which should be transcribed and transmitted to the referring doctor on a "stat" basis. It is at these "transitions of care" that there are risks to the patient. Both parties must be diligent to assure that key information (medications, test results, follow up requirements, etc.) is transmitted and acted upon in a clear and timely fashion. During the hospitalization, the hospitalist needs to communicate to the PCP if there are significant changes in the patient's condition; the PCP should be accessible if any new issues arise that may require further input or information.

11. Establish regular communication and dialog between the hospital leadership and the hospitalist program. Hospital leadership needs to review the performance of the hospitalist program to assure that the objectives are being met. The hospitalists need access to hospital administrators and medical staff leaders to address obstacles or barriers to their performance. In successful hospitalist programs, there are periodic meetings between the two parties at which these topics are discussed and action plans are developed for moving forward.

Operations/Management

12. Design a flexible schedule for the hospitalists that recognizes competing priorities and demands. A hospitalist's schedule should take into account the following variables:
    - Patient-hospitalist continuity over the course of the hospital stay. Ideally, a patient should see the same hospitalist throughout his or her hospital stay. This is likely to improve patient satisfaction, reduce errors, and increase hospitalist efficiency.
    - The bimodal distribution in work over the course of the day. A typical day for a hospitalist practice follows this pattern: 1) it is very busy with rounds on existing patients from early in the morning until sometime in the early afternoon; 2) then it is relatively quiet in the early afternoon; 3) finally it gets busy again with admissions from late afternoon until about 10 p.m. to midnight.
    - Sustainable physician lifestyle. Is the group's schedule one that a doctor could work for many years? Or do problems arise such as regular night work leading to sleep deprivation or working too few days annually so that each worked day requires a very high patient load? Does the schedule protect extended "block time off" but trade this for working too many days consecutively so that physicians are exhausted by the end of the "long stretch?"
    - Reasonable provision for night work. Once a hospitalist group is admitting six to eight patients per day, the program should consider a separate night shift staffed by a doctor who has no daytime responsibility the day before or after. Ideally, the practice should have one or more dedicated "nocturnists" who work only at night, while the remaining doctors in the group work only during the daytime.
    - Adaptability and scalability. Every group should think about how their schedule might change if/when patient volume grows and one or more doctors are added. Growth will often require changing the schedule significantly, rather than just adding new doctors into the existing scheduling rotation.

13. Staff the hospitalist program in a way that recognizes the potential for growth, the daily variations in patient volume, and the hospitalists' responsibilities: A significant problem encountered by many hospitalist programs is patient volume growth that occurs more quickly than anticipated. Recruiting lead times for hospitalists are long and physician turnover is common. A frequent cause of hospitalist practice crisis or failure is an overwhelmed hospitalist team. A hospitalist program should staff in a way that appropriately anticipates growth in patient volume.

    From day-to-day, there are significant variations in the volume of patients demanding care from hospitalists. Hospitalist staffing needs to recognize this variation. A cap on patient volume for individual hospitalists in the practice can be a useful tactic. Specifically, when one doctor reaches the cap in patients, other hospitalists help out. Finally, as previously described, hospitalists often have broad non-patient care responsibilities within the hospital — leading projects, staffing committees, etc. The hospitalist staffing model must provide sufficient "protected time" for these activities.

14. Track and report hospitalist performance measures against goals: In conjunction with the hospital and the medical staff, the hospitalist practice should establish performance goals and metrics. By tracking performance against these measures, variations can be picked up earlier in the process and corrective actions introduced. The program should generate periodic performance reports on parameters such as clinical quality, resource utilization, practice economics, physician productivity, and satisfaction (of patients, referring physicians, nurses, and hospitalists). These performance reports should be shared with the hospitalists in the practice and other stakeholders (e.g. hospital quality program) as appropriate.

15. Focus on effective revenue cycle management for the hospitalist program through systems, training, and reporting. Unless patient encounters are coded properly, billed accurately and promptly, and collected fully, the hospitalist practice will experience significant deficits and/or require excessive levels of subsidization. Hospital billing departments may not be familiar with the role of hospitalists. In those situations, seek out a vendor that has experience in the hospitalist field and check its references. Make sure it has integrated a compliance program into the coding and billing process and has the ability to provide complete activity and trend reports.

    Poor coding, especially under-coding, is a common problem among hospitalist programs. This is especially true for programs that have not implemented production based incentives. Educating the doctors in coding and undertaking regular audits of their performance is worth the effort and expense. It can lead to significant additional

revenue to the hospitalist practice, potentially reducing the amount of financial support required from the hospital or medical group.
(HP)

MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Hospital Admissions
The Massachusetts Medical Society adopts the following adapted from the American Medical Association policy:

The Massachusetts Medical Society advocates that hospital admission processes should include the following:

a. A determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician;
b. Prompt notification of such actively treating physician(s) where such a relationship exists;
c. Notice to the patient that they may request and receive treatment or consultation by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital;
d. Honoring patient requests that the physician of their choice treat them or consult on their care; and
e. Allowing actively treating physicians to treat to the full extent of their hospital privileges.

(HP)

MMS House of Delegates, 5/7/16
(Item 2 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 4/29/17)
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The MMS will maintain that the determination of the medical necessity for hospital admission should be made only by a doctor of medicine or a doctor of osteopathy licensed in the same jurisdiction as the treating physician. *(HP)*

The MMS supports principles for preadmission reviews of hospital admissions, including that such reviews should be performed by physicians or under close supervision of physicians; adverse decisions concerning hospital admissions should be finalized only by physician reviewers; and preadmission review programs should provide for immediate hospitalization of any patient whose treating physician determines the admission is an emergency. *(HP)*

MMS House of Delegates, 5/2/15
(Items 1 and 3 of Original Auto-Sunset; Time-Limited Directives Completed MMS House of Delegates, 5/7/16)
Reaffirmed MMS House of Delegates, 5/21/22

Hospital/Organized Medical Staff/Employed Physicians
The Massachusetts Medical Society adopts the following adapted from American Medical Association policy:

The MMS will actively educate Massachusetts physicians about the AMA Medical Staff Code of Conduct, and promote its use. *(D)*

The MMS will advocate for the separation between the terms of employment contracts and medical staff privileges. This separation includes an ongoing right of review for all physicians regardless of employment status with the organization. *(D)*

MMS House of Delegates, 12/2/17

The Massachusetts Medical Society adopts the following adapted from American Medical Association policy.

1. The MMS supports whistleblower protections for physicians — particularly employed physicians — who raise questions of quality, safety, and efficacy of health care and are adversely treated by any health care organization or entity. *(HP)*
2. The MMS will advocate for whistleblower protections in medical staff bylaws and incorporate these protections in the MMS Model Medical Staff Bylaws. *(D)*
3. The MMS will advocate for medical staff bylaws to include a provision for the development of a "medical staff forum" with open meetings on at least a quarterly basis, so medical staff members can meet with the hospital or health system administration to discuss issues of quality, safety, and the efficacy of health care within their organization. *(D)*

MMS House of Delegates, 4/29/17

All medical staff bylaws should include a provision that there be multiple secure communication methods for insuring that all the medical staff members are made fully aware of the timing and importance of elections and agenda items that require a vote. *(HP)*

At least one non-hospital-based physician should be represented on the medical executive committee, and stipulated in the medical staff bylaws. *(HP)*

Medical Staff by-laws should ensure that all physicians, employed and private, hospital-based and non-hospital based be treated equally.

The composition of the medical executive committee should reflect equitable percentages of the various voting categories. *(HP)*

MMS House of Delegates, 12/5/15
(Items 2-3 of Original Sunset MMS House of Delegates, 5/21/22)
(Item 4 of Original Reaffirmed MMS House of Delegates, 5/21/22)
(Items 1 and 5 of Original Amended and Reaffirmed and additional Item Added, MMS House of Delegates, 5/21/22)

The MMS will support and revise its model medical staff bylaws as appropriate to reflect the following guidelines regarding the qualifications and selection of individuals employed by or under contract with a hospital/health system to provide medical management services, such as medical directors, chief medical officers, and vice presidents for medical affairs:

a. The hospital governing body, management, and medical staff should jointly: (i) determine if there is a need to employ or contract with one or more individuals to provide medical management services; (ii) establish the purpose, duties, and responsibilities of these positions; (iii) establish the qualifications for these positions; and (iv) establish and sustain a mechanism for input from and participation by elected leaders of the medical staff in the selection, evaluation, and termination of individuals holding these positions.
b. An individual employed by or under contract with a hospital or health system to provide medical management services should be a physician (MD/DO).
c. A physician providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which he or she provides such services. Additionally, he or she should be a member in good standing of the organized medical staff of the hospital for which he or she provides medical management services.
d. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be licensed to practice medicine in each of the states in which the health system has a hospital that will be influenced by the physician's work. At a minimum, the physician should be licensed in at least one state in which the health system has a hospital over which the physician will exert influence, and in as many other states as may be required by state licensing law.
e. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be a member in good standing of the medical staff of each of the hospitals that will be influenced by the physician's work. At a minimum, the physician should: (i) be a member in good standing of at least one of the medical staffs of the hospitals that will be influenced by the physician's work; and (ii) work in collaboration with elected medical staff leaders throughout the system and with any individuals who provide medical management services at the hospital level.

(D)

2.The MMS will support and revise its model medical staff bylaws as appropriate to reflect the following guidelines regarding the role of the organized medical staff vis-à-vis individuals employed by or under contract with hospitals/health systems to provide medical management services:

a. The purpose, duties, and responsibilities of individuals employed by or under contract with the hospital/health system to provide medical management services should be included in the medical staff bylaws and in the hospital/health system corporate bylaws.

b. The organized medical staff should maintain overall responsibility for the quality of care provided to patients by the hospital, including the quality of the professional services provided by individuals with clinical privileges, and should have the responsibility of reporting to the governing body.

c. The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external agencies.

d. Government regulations that would mandate that any individual not elected or appointed by the medical staff would have authority over the medical staff should be opposed.

(D)

MMS House of Delegates, 12/6/14
Reaffirmed MMS House of Delegates, 5/8/21

That given the limited utility of medical staff-hospital compacts relative to their significant potential unintended consequences, the MMS recommends that organized medical staffs and physicians not enter into compacts or similar agreements with their hospitals' governing bodies or administrations. Instead, the MMS encourages organized medical staffs and hospital governing bodies to:

1. Clearly define within the medical staff bylaws the obligations of each party;
2. Outline within the medical staff bylaws the processes by which conflicts between the organized medical staff and the hospital governing body are to be resolved; and
3. Regard the medical staff bylaws as a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body.

(HP)

MMS House of Delegates, 12/7/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society adopts the following Principles for Physician Employment:

Principles for Physician Employment
1. Addressing Conflicts of Interest

(a) A physician's paramount responsibility is to his or her patients. Additionally, an employed physician is likely to feel some sense of obligation to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

(b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

(c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

(d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(e) Taking a title or position that removes a physician from direct patient care does not override professional ethical obligations. Physicians whose administrative actions or business decisions override the individual patient care decisions of other physicians are engaged in the practice of medicine and subject to professional ethical obligations, and may be held legally responsible for such decisions.

(f) Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms that exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

2. Advocacy for Patients and the Profession

(a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice.

(b) Advocacy for the profession is also a fundamental element of the delivery of quality care and it too, should not be altered by the health care system or the methods by which physicians are compensated.

(c) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

(a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

(b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties should obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

(c) When a physician's compensation is related to the revenue he or she generates, or similar factors, the employer should make clear to the physician the factors upon which compensation is based.

(d) Termination of an employment or contractual relationship between a physician and its employer does not necessarily end the patient-physician relationship between the employed physician and persons under his or her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee as stated in the physician employment contract and as governed by law.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.

(f) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

4. Hospital Medical Staff Relations

(a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

(b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

(c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

(d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

5. Peer Review and Performance Evaluations

(a) When entering into an employment contract physicians should accept, and be subject to, an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

(b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

(c) Peer review of employed physicians should be conducted independently of, and without interference from, any human resources activities of the employer. Physicians - not lay administrators - should be ultimately responsible for all peer review of medical services provided by employed physicians.

(d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

(e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Unless specified otherwise in the employment agreement, upon termination of employment with or without cause, an employed physician should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

6. Payment Agreements

(a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

(b) Employed physicians should retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

7. Physician Independence and Self-Governance

(a) The MMS will (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks, and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.
(b) The MMS will disseminate the Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the Massachusetts Hospital Association and the Massachusetts Medical Group Management Association.
(HP)

The MMS:
(1) adopts as policy the principle that a medical staff member's financial relationships, including employment or contractual relationships, or lack thereof, with a hospital or health care delivery system should not determine the

physician's eligibility for: election or appointment to medical staff leadership positions; voting on medical staff matters; or otherwise participating in the self-governance activities of the medical staff.

(2) will continue to update and encourage medical staffs to adopt model medical staff bylaws provisions supporting the principle that a medical staff member's financial relationships including employment or contractual relationships, or lack thereof, with a hospital or health care delivery system should not determine the physician's eligibility for: election or appointment to medical staff leadership positions; voting on medical staff matters; or otherwise participating in the self-governance activities of the medical staff and encourage medical staffs to adopt and incorporate into their bylaws conflict-of-interest policies that reflect the following principles:

(a.) Full disclosure of conflicts.

– Nominees for election or appointment to medical staff offices, department or committee chairs, including all members of the nominating committee, or the medical executive committee should fully disclose in writing to the medical staff, prior to the date of election or appointment, any

- personal,
- professional,
- or financial affiliations or relationships of which they are reasonably aware – including employment or contractual relationships, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

– Elected or appointed medical staff leaders should fully disclose such Conflicts of interest in writing to the medical staff whenever they arise.

(b.) Management of conflicts. Once fully disclosed, when conflicts of interest exist:
– Elected or appointed medical staff leaders should, as appropriate, voluntarily abstain from voting on the matter to which the conflict relates, or recuse themselves from the decision-making process and participation in the matter to which the conflict relates.
– The medical staff should establish a process for involuntarily recusal of any elected or appointed medical staff leader who fails to fully disclose a potential conflict of interest, to abstain from voting, or to recuse himself or herself from the decision-making process and participation in the matter to which the conflict relates.
(HP)

MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society (MMS) encourages each hospital medical staff in the Commonwealth to include at their regular meetings a report from a member of the medical staff in a leadership position of the district or state society that would provide timely details of events, activities, and issues pertaining to organized medicine. *(HP)*

The MMS will provide assistance to such representatives in their preparation of these reports pertaining to organized medicine for hospital medical staff meetings. *(HP)*

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

The Massachusetts Medical Society should become the lead association for physicians in Massachusetts who maintain employment or contractual relationships with hospitals, health systems, and other entities. *(D)*

The MMS will work through the Organized Medical Staff Section, other sections and special groups, or a newly created section (similar to the AMA's Integrated Physician Practice Section) as appropriate to represent and address the unique needs of employed physicians in hospitals, health systems, and other entities. *(D)*

That as a benefit of membership, the MMS should provide assistance through existing resources and the Organized Medical Staff Section, such as information and advice (but not legal opinions or representation) as appropriate to residents and fellows, employed physicians, physicians in independent practice, and independent physician contractors. Such information and advice should address matters pertaining to their relationships with hospitals, health systems, and other

entities, including, but not limited to, breach of contracts, medical staff bylaws, sham peer review, economic credentialing, and the denial of due process. *(D)*

MMS House of Delegates, 5/19/12
(Reaffirmed MMS House of Delegates, 12/5/20)

The Massachusetts Medical Society supports policy stating that an existing medical staff should have the right to reorganize and redefine its own governance structure as appropriate. *(HP)*

The MMS will advocate for all properly licensed and hospital credentialed physicians involved in patient care to be eligible for voice and vote in organized medical staff self-governance. *(D)*

The MMS supports policy that affirms that the medical staff, as a principle of self-governance, should be a representative democracy where the members personally participate with voice and vote in the decision-making and election of their representatives. *(HP)*

MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society (MMS) supports a minimum set of self-governance attributes of the hospital medical staff, the essence of which will lead to improved patient care and better relationships between hospitals and their physicians, and would include:

- The initiation, development, adoption, and amendment of medical staff bylaws, rules, and regulations, subject to approval of the hospital governing body, from which approval shall not be unreasonably withheld
- The establishment and enforcement of criteria and standards for medical staff membership and privileges consistent with applicable laws and regulations, as well as with MMS policy and American Medical Association and the Joint Commission standards, and other accrediting organizations with deeming status
- The establishment and enforcement of clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities such as periodic meetings of the medical staff and its committees and review and analysis of patient medical records
- The selection and removal of medical staff officers
- The establishment and collection of medical staff dues and use of the dues fund consistent with the purposes of the medical staff
- The right of the medical staff as an entity to access and use independent legal counsel at the expense of the medical staff
- The right of the medical staff to seek an injunction in court to protect its self-governance authority from interference by the hospital governing body or administration

(D)

MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society will continue to work to bring about a better understanding and collaboration between hospitals and physicians. (*D)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Hospital Mergers or Conversions
Statement of Principles for Conversions and Mergers

A. Community Health Impact:

(1) Any proposed merger or conversion should assure access to high quality patient care and medically necessary services appropriate to the community's needs.

(2) The proposed new entity should be obligated to provide the same or enhanced levels of services in the following areas:

- care to the uninsured and other vulnerable populations
- community health
- education and teaching
- research

(3) The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger and should be committed to for a defined period. Procedures should be established for effective independent monitoring of those services to assure compliance with the agreed upon commitments and assessment of their effect on the community health status.

(4) Public hearings should be held to assure full public discussion of the proposed new entity and community concerns should be given full hearing. The proposed new entity should develop a written plan which addresses those community concerns before final approval of the proposed conversion or merger.

B. Oversight Requirements

(1) There should be full compliance with all requirements set forth by the Office of the Massachusetts Attorney General and the Massachusetts Department of Public Health.

(2) An independent appraisal of assets should be completed prior to a for-profit conversion.

(3) Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited.

(4) All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed.

(5) The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation.

(6) The level of compensation for officers, trustees, directors and employees of the newly formed entity and the charitable foundation, when applicable, should be at an appropriate market rate.

Implementation Strategies

(1) Issue: Staffing Levels – With respect to Principle A.1.: "Any proposed merger or conversion should assure access to high quality patient care . . .." One key determinant of the quality of patient care is the adequacy of medical staffing. Strategy: After the conversion or merger, staffing levels should be appropriate to provide high quality patient care.

(2) Issue: Service Changes – With respect to Principle A.3.: "The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger . . ." Appropriate information needs to be made available to the community in a timely manner, so as to enable the community to provide effective input to the process. Strategy: The new entity should identify both current services and those services it proposes to provide. As further modifications of services are proposed, the community should be informed and their input sought.

(3) Issue: Monitoring – With respect to Principle A.3.: "Procedures should be established for effective independent monitoring . . .." Because the affected community has the most at stake, it should be given the mandate and resources needed to perform this task. Strategy: Effective monitoring may be achieved by a local advisory board with significant autonomy.

(4) Issue: Private Inurement – With respect to Principle B.3.: "Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited." Decisions regarding conversions and mergers should be made solely on the basis of the best interests of the converting or merging entity and the community it serves. Strategy: Such abuses of trust should be aggressively investigated and prohibited by law or regulation, with penalties for violations.

(5) Issue: Conflicts of Interest – With respect to Principle B.4.: "All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed." The purpose of this recommendation is to inform the community about the possible motives of key decision-makers in the conversion or merger process. Strategy: All disclosures of conflicts of interest should be documented in writing.

(6) Issue: Charitable Foundations – With respect to Principle B.5.: "The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation." And, Principle B.6., states: "The level of compensation for officers, trustees, directors and employees of . . . the charitable foundation . . . should be at an appropriate market rate." Charitable foundations formed with the assets of a converting entity have great potential for being misused. Strategy: The mission, governance, operations and management of such foundations should be subject to public scrutiny and focused on health care.

(HP)

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
(Reaffirmed MMS House of Delegates, 5/4/19)

Neonatal Intensive Care Unit Services

The Massachusetts Medical Society will support the wise use of the Neonatal Intensive Care Unit (NICU) and advocate to legislators and insurers for regulations that eliminate medical-insurance obstacles that prevent the transport of stabilized infants to a lower level of neonatal care, when appropriate. *(HP/D)*

MMS House of Delegates, 12/1/18

The Massachusetts Medical Society (MMS) will continue to oppose defining levels of neonatal care based on the volume of deliveries at a hospital. *(D)*

The MMS will continue to work with the Massachusetts Department of Public Health and with the Massachusetts Hospital Association to ensure continued quality surveillance of neonatal outcomes. *(D)*

MMS House of Delegates, 12/3/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 12/5/20

Network Adequacy

The MMS adopts the following adapted from American Medical Association policies to address the issue of network adequacy for patient access:

The MMS supports the Massachusetts Legislature, the Division of Insurance, and other appropriate state regulators as the primary enforcer of network adequacy requirements for patient access. *(HP)*

The MMS supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. *(HP)*

The MMS supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy as evaluated by patient access measures, including geographic location, the number and type of providers that have joined or left the network, the number and type of specialists and subspecialists that have joined or left the network, the number and types of providers who have filed an in-network claim within the calendar year; the total number of claims by provider type made on an out-of-

network basis; data that indicates the provision of Essential Health Benefits; and consumer complaints received. *(HP)*

The MMS supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. *(HP)*

The MMS supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. *(HP)*

The MMS supports state legislative and regulatory efforts to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. *(HP)*

The MMS supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. *(HP)*

The MMS will advocate for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies. *(D)*

The MMS will advocate for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited. *(D)*

The MMS will advocate that health plans should be required to document and report to regulators that they have met requisite standards of network adequacy for hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists, and hospitalists) at in-network facilities. *(D)*

MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Patient and Family Advisory Councils
The MMS supports the inclusion of feedback from Patient and Family Advisory Councils in guiding hospitals as they deliver quality health care. *(HP)*

MMS House of Delegates, 12/3/16
Reaffirmed MMS House of Delegates, 5/13/23

Pediatric Hospital Care
The MMS will work with relevant stakeholders to encourage equal access to essential pediatric care without undue financial burden by assessing the effectiveness of interventions, including the following:

1. Alternative pediatric care payment models;
2. Medical transportation coverage and other strategies to defray cost of physical barriers caused by regionalized care;
3. Developing digital cross-sector care coordination at the state level.

The MMS will work with relevant stakeholders to develop state recommendations to alleviate barriers to accessing regionalized pediatric care, especially inpatient pediatric care. *(D)*

The MMS will work with relevant stakeholders to develop an inpatient pediatric care crisis action plan that includes financial and logistical support to ensure care delivery during surges of inpatient need considering the youth mental health crisis and future pediatric national emergencies. *(D)*

MMS House of Delegates, 12/9/23

Personal and Financial Information
That because inappropriate disclosures and use of physicians' personal and financial information may not be prohibited by law, the Massachusetts Medical Society (MMS) will take prompt action to inform hospital medical staff members about the risks involved in disclosing personal and financial information (including proprietary business, ownership, strategic, and income information) until hospital administrators have taken steps to protect that information from misuse and wrongful disclosure. Such measures must include adoption of strictly enforced policies approved by the medical staff that specifically govern the maintenance, disclosure, use, and destruction of medical staff members' personal and financial information. *(D)*

The MMS will inform hospital medical staff members about the risks involved in disclosing personal and financial information (including proprietary business, ownership, strategic, and income information) to comply with hospital conflict of interest policies, because such policies may serve as a pretext to identify physician "competitors," and because such information is irrelevant to granting and exercising practice privileges. *(D)*

The MMS will inform hospital medical staff leaders about the risks involved in broad disclosures of personal and financial information (including proprietary business, ownership, strategic, and income information) pursuant to hospital conflict of interest policies for medical staff leaders, as such information is not relevant to medical staff leadership responsibilities (which are to oversee and improve patient care in hospitals), noting, however, that such disclosures may be required of hospital medical staff leaders who also serve on the board of directors of a hospital, as these individuals rightfully can be subject to a conflict of interest policy in furtherance of their duties. *(D)*
The MMS will provide information to medical staffs about steps they should take to protect members' personal and financial information (including proprietary business, ownership, strategic, and income information) that otherwise is not protected from dissemination and use. *(D)*

The MMS will initiate legislative efforts to safeguard the confidentiality of hospital medical staff members' personal and financial information (including proprietary business, ownership, strategic, and income information) disclosed pursuant to hospital conflict of interest policies. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Specialty Care/Independent Physicians
The MMS takes the position that there should be equal promotion of, and access to inpatient consults for, credentialed and privileged community/independent specialty physicians as for hospital-employed specialty physicians. *(HP)*

The MMS will advocate that hospitals engage community/independent specialty physicians on the medical staff for observation, inpatient and emergency department coverage, and that the parties negotiate mutually satisfactory payment terms and service agreements for such service. *(D)*

MMS House of Delegates, 5/21/22

Temporary Privileges
The MMS adopts the following adapted from American Medical Association policies:
The Massachusetts Medical Society support the use of temporary privileges in the following situations:

a. To fulfill an important patient care, treatment, or service need, or
b. When an applicant for new privileges with a "clean" application is awaiting review and approval by the medical staff executive committee and the governing body. *(HP)*

The Massachusetts Medical Society will work with the American Medical Association and other stakeholders to preserve the use of temporary privileges in the following situations:

a. To fulfill an important patient care, treatment, or service need, or
c. When an applicant for new privileges with a "clean" application is awaiting review and approval by the medical staff executive committee and the governing body. *(HP)*

MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Uniform Standards for Non-Profits and For-Profits
The Massachusetts Medical Society supports the concept that all for-profit hospitals or health care delivery systems be held to the same standards as not-for-profit hospitals or health care delivery systems in providing free care, support for medical education and research, and commitment to the needs of their respective communities. (HP)

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Visiting Hours
The MMS recognizes that adopting open visitor policies in hospitals increases patient and family satisfaction with care, can improve a variety of patient related clinical outcomes, and overall patient health. *(HP)*

The MMS will work with the Massachusetts Hospital Association, Massachusetts Nurses Association, the Department of Public Health, and other interested parties to advocate that hospitals in Massachusetts actively conduct a thorough review of their visitation policies and update these policies to implement less restrictive, more open visitation policies. *(D)*

MMS House of Delegates, 12/9/23

LEGAL MEDICINE

Due Process
The Massachusetts Medical Society calls for due process for physicians, including resident physicians, before any adverse action is taken by entities with whom the physician has a professional, contractual, or employment relationship to provide patient care. *(HP)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Item 1 of Original: Reaffirmed, MMS House of Delegates, 5/19/12
(Item 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society will frame and support legislation to prohibit insurance companies from making material changes in existing signed agreements with physicians, particularly those changes that are deleterious to patients' interests, without giving prior written notification and a reasonable opportunity for 'meaningful' negotiations with individual physicians or their designees. *(D/HP)*

The Massachusetts Medical Society will frame and support legislation to require insurance companies to submit any disputes with physicians over material changes in existing provider contracts, particularly those changes that are deleterious to patients interests, to binding arbitration, if challenged. *(D/HP)*

The Massachusetts Medical Society encourages insurance and managed-care companies to negotiate contracts with physicians in fairness and good faith, without open-ended clauses and unilateral rights to amend. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND ORGANIZATION

Board of Trustees/Officers

The MMS will continue to convene a Governance Reform Working Group each presidential year, with members appointed by the president, inclusive of representatives from diverse backgrounds, experience, and specialties, and from districts of varying size and geographic location and be aligned with the Governance/Structure policy passed at I-20: … *The MMS will develop a process that is effective, transparent, and inclusive to examine alternative approaches to structure and governance and associated financial considerations of the Society. … (D)*

The establishment of district groups/regions must have a selection mechanism through the District Leadership Committee* to assure fair distribution of trustees among districts of varying sizes and geography and will be solely for the purpose of electing district group/regional trustees. *(D)*

District groups/regions established for the purpose of electing trustees to the Board shall elect their own trustees, using a nomination process that assures rotation among districts within each group. *(D)*

Any possible future election process for at-large trustees that allows direct election by the House of Delegates must include guidelines for campaigning and politicking. *(D)*

MMS House of Delegates, 5/13/23
**["Committee"pending Bylaws amendment @ Annual Mtg of the Society, A-24]*
(Regions and trustee information pending Bylaws Amendment)

…

2. The MMS requests that MMS Bylaws be amended to implement the following:

The Board of Trustees shall consist of a trustee from each of six regions elected for a term for three years and may be re-elected for one additional term, five statewide trustees elected for a term of three years and may be re-elected for one additional term…* [Resident and Fellow Section primary and secondary trustees] with a one-year term renewable up to five years, [Medical Student Section primary and secondary trustees] with a one-year term renewable up to five years…
**[re: terms of trustees – pending Bylaws Amendment]*
…
e. That the MMS eliminate district-elected board of trustee positions.
f. That the MMS establish six regions.
g. Each region will include a number of districts; the actual regional map will be determined by our District Leadership Council.
h. That the MMS create six regional trustee positions on the Board of Trustees. Each regional trustee shall serve for a term of three years and may be re-elected for one additional term.

- Each region with an open regional position will nominate a minimum of two trustee candidates to fill each open regional seat, to serve a three-year term.

i. That the MMS create five statewide trustee positions on the Board of Trustees. Each statewide trustee shall serve for a term of three years and may be re-elected for one additional term.

- The Committee on Nominations will submit a slate to the HOD for a vote for open statewide trustee positions for election to a three-year term each.

MMS House of Delegates, 5/21/22
(Item 1 of Original: Sunset, Bylaw Amendment Completed)
(Item 2 of Original parts a-d and j-l, Bylaws Amendment Completed)
(Item 2 of Original regarding number of regions, trustee position terms, pending Bylaws Amendment)
(Item 2 of Original parts e-i, pending Bylaws Amendment)
(Item 2 or Original part h, bullet, Amended, MMS House of Delegates, 5/13/23)
(Item 2 regarding number of regions, trustee position terms, Amended MMS House of Delegates, 12/9/23)
(All: Pending Bylaw Amendment)

Boston Medical Library
The MMS will explore mechanisms to advocate for members to obtain expanded electronic access to more core medical journals. *(D)*

MMS House of Delegates, 5/19/12
(Items 1-2 of Original: Sunset, MMS House of Delegates, 5/4/19)
(Reaffirmed for One Year Pending Review at A-20, MMS House of Delegates, 5/4/19)
(Reaffirmed for Six Months Pending Review at A-21)
(Reaffirmed for One Year Pending Review at A-22)
(Reaffirmed for One Year Pending Review at A-23)
(Reaffirmed for One Year Pending Review at A-24)

The Massachusetts Medical Society (MMS) will continue its support for the Boston Medical Library (BML) and the Waltham branch of the BML/ Countway Library. *(D)*

The MMS will continue its role with the BML and promote the library and access to its members and continue monetary and in-kind contributions to the BML, which in turn supports the continuation of the BML Branch services at MMS Headquarters. *(D)*

The MMS will continue to provide an annual "commitment of support" to the BML. *(D)*

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Budget
Programs or initiatives will be assigned a priority, and approved by the Board of Trustees. *(HP)*
*(*Amended and Reaffirmed MMS House of Delegates 5/9/08; Original Policy Sunset)*

Appropriate resources will be directed to program areas in order of priority.

The Board of Trustees will be delegated to assign a supplemental budgetary appropriation, action plan, and timeline for programs and initiatives. *(HP)*

Management will continue its work to achieve budgetary and operational savings and report to appropriate committees and the Board for guidance and approval. *(HP)*

The HOD may modify the priority list of the BOT and adjust the priority list with a super majority of a 2/3 vote of the House. *(HP)*

The BOT shall include in its report the total budget to be allotted to new programs approved by the HOD, and the HOD may modify this budget by a 2/3 majority vote. *(HP)*

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Committees/Sections

The Massachusetts Medical Society requests that the MMS Bylaws be amended to implement the following:

The MMS Secretary-Treasurer shall serve as the Chair of the Committee on Finance.

The term of the MMS Secretary-Treasurer shall be amended to one three-year non-renewable term. *(D)*

MMS House of Delegates, 12/9/23
(Pending Bylaw Amendment)

That beginning in FY23, the work of all current special committees and any proposed future special committees be aligned within any future governance model including the existing standing committees, task forces, sections or member interest networks. *(D)*

MMS House of Delegates, 5/21/22

All requests for approval of committee continuance should include a brief written evaluation and recommendation by the Board of Trustees based on:

- How well the committee met its stated objectives
- Frequency of meetings and attendance
- Evidence of an effective work product
- Additional evidence (such as educational benefit, publications, increased membership, etc.)
- Reasonable cost to the Massachusetts Medical Society (MMS) for work performed
- Uniqueness of the committee (i.e., function not duplicated elsewhere in the Massachusetts Medical Society)

(D)

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
(Reaffirmed for One Year Pending Review at A-23)
(Reaffirmed for One Year Pending Review at A-24)

Committee on Senior Volunteer Physicians Free Health Care Program

The Massachusetts Medical Society will support and fund requests for professional liability insurance from MMS senior physician member volunteers that are approved through the Committee on Senior Volunteer Physicians Free Healthcare Center Program. (D)

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

Conflicts of Interest Policy

The Massachusetts Medical Society (MMS) Policy Statement on Conflicts of Interest states:

POLICY STATEMENT ON CONFLICTS OF INTEREST

MMS delegates, trustees, officers, committee members, and agents assume a fiduciary duty to act in the best interests of MMS, as well as in accordance with applicable state and federal laws and regulations. A conflict of interest occurs when a delegate, trustee, officer, committee member, or agent has a material financial or beneficial interest which is likely to affect decisions made by or on behalf of MMS, or participates in other activities which significantly may impair the objectivity of or inappropriately influence the delegate's, trustee's, officer's, committee member's, or agent's decisions or actions on MMS matters.

It shall be the policy of MMS that its delegates, trustees, officers, committee members, and agents shall either abstain from participation in such MMS decisions or activities or shall make full disclosure of conflicts or potential conflicts of interest. Such disclosure shall be to the Board of Trustees in accordance with procedures which the Board shall from time to time adopt.

MMS Officers, during their term of office and for two years thereafter, shall not assume any administrative position with an organization for which MMS appoints, elects, or nominates officers and/or directors without the approval of the Board of Trustees.

The Board of Trustees procedures pertaining to conflicts of interest shall be implemented in a manner which is intended to be legally enforceable. Questions regarding application of this policy and the Board's procedures shall be resolved by the Committee on Administration and Management.

(HP)

MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Cotting Luncheon
The Massachusetts Medical Society will continue to honor benefactor Dr. Benjamin Eddy Cotting by designating a luncheon at either the Annual or Interim House of Delegates meeting as the "Cotting Luncheon." *(HP)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

District Medical Societies
The MMS requests changes to the MMS bylaws to implement the following:

That the District Leadership Council should be reconstituted as a standing committee of the MMS and be renamed the District Leadership Committee.

a. The charge of the District Leadership Committee shall be to ensure the ongoing strength and viability of the MMS districts through communication with the Presidential Officers and Board of Trustees, and through discussion and submission of policy and reports to the House of Delegates.

b. That all officers of MMS district societies are invited to participate as members of the District Leadership Committee.

   i. That voting within the District Leadership Committee will be by majority votes with one vote per district by its voting member or alternate voting member.

   ii. The process for selecting a voting member and alternate to the District Leadership Committee shall be determined by each individual district as certified by the District's president.

   iii. The Medical Student Section and the Resident and Fellow Section will each be allowed one (1) section member in attendance at District Leadership Committee meetings without the right to vote.

c. That District Leadership Committee term lengths will be one year, renewable for as long as the member is an officer of an MMS district society.

d. That the Chair and Vice Chair of the District Leadership Committee will be selected by members of the committee at the first meeting of each presidential year and serve for a term of up to two years, renewable up to a total of four years, based on eligibility as a District officer.

   i. If a Chair of the District Leadership Committee terms off the committee prior to their two-year term in Committee leadership, then the Vice Chair shall assume the role of Chair for the remainder of the term, and this time shall not count towards the total four years of eligibility as Chair.

   ii. If a Vice Chair of the District Leadership Committee terms off the committee prior to their two-year term in Committee leadership, then the Committee members shall select a new Vice Chair to complete the remainder of the term in office, and this time shall not count towards the total four years of eligibility as Vice Chair.

(D)

MMS House of Delegates, 5/13/23
(Pending Bylaw Rept. at I-23)
(Pending Bylaws Amendment at Annual Meeting of the Society, at A-24)

The Massachusetts Medical Society (MMS) will offer each of the following services to the District Medical Societies at cost through a charge-back system to the districts:

- Accounting services – including annual financial statement
- Tax preparation service
- Bookkeeping
- Non-profit tax disclosure regulation compliance (such as public inspection of tax returns)

No district is obligated to take advantage of services offered through the MMS, but each district is encouraged to utilize the expertise available through the Society if it would help the district operate more effectively.

(D)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 5/21/22

Diversity, Equity, and Inclusion
The MMS will convene a roundtable of the main players in the healthcare arena, such as the Health Care Workforce Center of Massachusetts, Massachusetts Health Policy Commission, the Massachusetts Health and Hospital Association, the Massachusetts Department of Public Health, medical school deans and diversity officers for the medical schools, hospital residency program directors, and hospital department chairs to discuss the importance of racial and ethnic data collection, the impact on physician diversity and health care disparities, and the progress in physician diversification in Massachusetts, and to determine best practices and next steps. *(D)*

The MMS will ask the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education, and the American Medical Association to report on their respective data reports on medical students, residents, active physicians, and institutional faculty so that 1) racial data is consistently reported separately from ethnic data for all groups; 2) both racial and ethnic data is provided for enrollees and graduates for all medical schools; 3) the racial and ethnic demographic information for residencies is provided by state or by institution so these bodies can accurately assess their progress; and 4) this data is made readily available online to interested parties. *(D)*

MMS House of Delegates, 5/21/22

The MMS recognizes that race is a social construct and does not reflect biological or genetic diversity between groups. *(HP)*
The MMS will call on all editors and reviewers of medical literature to review and reconsider the validity of the use of race in clinical algorithms and laboratory measurements, both in prior and future publications. *(D)*

The MMS will call for researchers, journals, and peer reviewers to rigorously examine racism and how it perpetuates racial health inequities. *(D)*

The MMS will call for medical journals to actively increase the diversity of their editorial boards. *(D)*

The MMS will support efforts at the state and national levels to 1) recognize race as a social, not biological construct, 2) identify the ways in which racism, rather than race, leads to health inequities, and 3) critically examine the use of race in clinical algorithms and laboratory measurements. *(D)*

MMS House of Delegates, 12/5/20

The MMS, independently and in collaboration with other groups such as the four Massachusetts medical schools, and the Association of American Medical Colleges, will actively work and advocate for funding at the federal and state levels and in the private sector to support the following:

(a) Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school, beginning early in their academic careers
(b) Diversity or minority affairs offices at medical schools
(c) Financial aid programs for students from groups that are underrepresented in medicine
(d) Financial support programs to recruit and develop faculty members from underrepresented groups *(D)*

The MMS will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community. *(D)*

The MMS will offer education programs to its members that support capacity building and advocacy training on the issues and possibilities involved in creating a diverse physician workforce. *(D)*

The MMS will support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine, to health care careers. *(D)*

The MMS will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education. *(D)*

The MMS will develop and implement a plan with input from the relevant MMS committees, sections, and other stakeholders to expand demographics collected about our members which may be given voluntarily by members and will be handled in a confidential manner. *(D)*

The MMS will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to underrepresented groups in medicine. *(D)*

The MMS will work with the Association of American Medical Colleges and other stakeholders and encourage analysis of pipeline programs (also known as pathway programs) participation in order to assess the effectiveness of pipeline programs. *(D)*

MMS House of Delegates, 12/5/20

Grants-in-Aid

The Grants-in-Aid program will be changed from an application and approval process to a maximum $5,000 grant given by the Massachusetts Medical Society annually to any district, upon request, for support of district activities. *(D)*

The district participating in the Grants-in-Aid program annually will report back to the District Leadership Council as to the use of these funds. *(D)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Historical Preservation

The MMS's commitment to preserving and protecting its heritage will be an ongoing initiative and implemented in stages over time. *(D)*

The MMS will preserve and strengthen the collaborative relationship with the Boston Medical Library (BML) and the Center for the History of Medicine at the Countway Library of Medicine for the purpose of maintaining MMS and district historical records and artifacts. *(D)*

The MMS will continue its oral history program to preserve the contributions of past MMS presidents and other MMS leaders. *(D)*

The MMS will coordinate potential display opportunities of the history of the Massachusetts Medical Society (and its district medical societies), the oldest medical society in continuous existence in the United States. *(D)*

That, as part of its record retention policy, the MMS will include provisions to specifically address the preservation of documents being created now that will have historical value in the future. (D)

MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The MMS will focus its review and actions concerning historical documents on preserving and protecting the documents, electronic files, and artifacts of the MMS and its district medical societies. *(D)*

MMS House of Delegates, 5/9/08
(Items 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

House of Delegates

The House of Delegates will operationalize their goal of greater gender equity by aiming for parity in women physician delegates within three years. *(D)*

The MMS will update and distribute educational materials to members regarding the role of the House of Delegates in policy making, with explicit inclusion of benefits associated with gender equity in the creation of strong policy. *(D)*

The MMS will create an internal campaign using existing MMS web/print channels and emails to recruit women physicians for delegate and other medical society leadership positions. *(D)*

The MMS will educate district leadership on specific strategies to recruit delegates to better reflect the current gender composition of physicians. *(D)*

The MMS Women's Physician Section will establish a social media presence owned and managed by MMS physicians with staff oversight with the purpose of supporting current female physician members, recruiting women physicians as members, and demonstrating MMS governance and leadership opportunities available to women. *(D)*

MMS House of Delegates, 5/8/21

The MMS recommends that all committees evaluating a referred HOD resolution/report make a reasonable effort to contact the referred resolution's author. *(D)*

MMS House of Delegates, 12/7/19

The MMS will provide dedicated "family friendly" space at the House of Delegates meetings (beginning with A-17) to allow MMS members with infants and young children to remotely view the proceedings of the House of Delegates. *(D)*

(Approved MMS Board of Trustees, 3/8/17)
Accepted MMS House of Delegates, 4/29/17
(Item 2 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 12/2/17)

The MMS will continue to promote the onsite family-friendly space at Interim and Annual Meetings and provide contact information of available resources to members inquiring about other available services. *(D)*

(Approved MMS Board of Trustees, 9/6/17)
Accepted MMS House of Delegates, 12/2/17

The Speakers of the House of Delegates shall remind and educate delegates about a) their parliamentary right to call for a counted vote and b) that electronic keypads will be used for a request for a counted vote (division) or an initial counted vote. *(HP)*

In order for a ballot vote to be taken by any method other than electronic keypads, a motion and approval by a majority vote shall be required, unless otherwise specified in the Bylaws or Procedures of the House of Delegates. *(HP)*

MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Finance Committee of the Massachusetts Medical Society will review all regularly submitted and late resolutions that have a fiscal note of $5,000 or greater and make a recommendation as to the fiscal impact of each resolution to the House of Delegates. *(HP)*

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

That whenever possible, fiscal notes will be amended to reflect the recommendations of a reference committee in its report to the House of Delegates. *(HP)*

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society will reimburse delegates attending a meeting of the House of Delegates for the cost of their overnight accommodations for up to two nights, if needed. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

The MMS will request that the districts work toward selecting delegates that better reflect the composition of practicing physicians in the Commonwealth (as registered with the Board of Registration in Medicine) by considering such factors as gender, specialty, age, race/ethnicity, gender identity, sexual orientation and other demographics. *(D)*

MMS House of Delegates, 11/3/07
(Item 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Leadership Development/Ambassador Program
The Massachusetts Medical Society will promote representation in its leadership and committees that reflects the Society's membership and demographics diversity. *(D)*

MMS House of Delegates, 12/3/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The current criteria for selection of ambassadors and a coordinator for the program includes the following:

1. The selected ambassadors will attend the AMA Annual Meeting, and fully participate by shadowing MMS delegates/alternates and attend all scheduled delegation meetings and House of Delegates sessions at the AMA Annual Meeting (currently beginning at 6pm Friday and concluding at noon Wednesday) unless the ambassador has reasonable alternatives that would benefit the Massachusetts AMA delegation and are approved by the ambassador program coordinator.
2. The applicant must be an MMS member and have indicated his or her willingness to serve, should they be selected.
3. The applicant may self-nominate.
4. The applicant may be interviewed by the chair of the AMA Delegation and/or the coordinator of the Ambassador Program.
5. The applicant should ideally never have attended a meeting of the AMA House of Delegates.
6. The selection decisions should be made by the AMA Delegation.
7. The selected ambassador(s) should later, in person or in writing, report to the MA AMA Delegation and the MMS House of Delegates (HOD) regarding their reflections on their experience within this program.
8. The coordinator and AMA Delegation chair will maintain an ongoing report to the HOD documenting the alumni, the history of the program, and the resultant effect as to its intended goal.
9. The MA AMA Delegation will select the coordinator from among the MMS elected delegates and alternates.
10. A maximum of two (2) ambassadors will be selected annually.

(HP)

MMS House of Delegates, 12/4/10
Amended and Reaffirmed MMS House of Delegates, 12/1/12
Amended and Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The existing criteria for selecting [Ambassador Program] nominees shall include: trustees or alternate trustees to the Board of Trustees (BOT), and/or chair, vice chair, or members of MMS committees, sections*, and/or district officers. *(D)*

The recruitment process will be expanded to include online, written, and personal outreach. *(D)*

The evaluation process for the Ambassador program will be expanded to include formal feedback from mentors, ambassadors, and the AMA delegation. *(D)*

MMS House of Delegates, 11/15/08
Item 3: Amended and Reaffirmed MMS House of Delegates, 12/5/09*
Reaffirmed (and Items 1, 2, and 4 of Original Sunset) MMS House of Delegates, 12/1/12)
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The Massachusetts Medical Society (MMS) will continue its generous support of medical students by providing travel funding for students serving in official functions to attend the Annual and Interim Meeting of the American Medical Association (AMA) Medical Student Section (MSS). *(D)*

The MMS-MSS Governing Council officers will choose four medical "student ambassadors" who are first-time attendees to attend the AMA-MSS Annual and Interim Meetings. *(D)*

All medical students receiving funding to attend the Annual and Interim Meetings of the AMA-MSS from the MMS shall agree to sign and abide by the "Requirements for all AMA-MSS Meeting Attendees Funded by the MMS" developed by the MMS-MSS Governing Council, which outlines responsibilities of funded individuals and usage of funding. *(D)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Item 3 of Original: Amended/Sunset MMS House of Delegates, 12/1/12)
Reaffirmed MMS House of Delegates, 5/4/19

Leadership Development

The Massachusetts Medical Society, when reviewing the current governance structure, will consider the process for appointment to standing and special committees and opportunities for committee leadership to ascertain whether there are opportunities for improvement in process, inclusion, diversity, and representation of best practices. *(D)*

MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) will continue its support of leadership development by providing funds for registration and reasonable travel expenses, in accord with current Society policies on travel reimbursement for Society members on official business, for one medical student from each of the four Massachusetts medical schools, as selected by the Governing Council of the MMS Medical Student Section, to attend the American Medical Association Medical Student Advocacy Day. *(D)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Membership/Benefits/Dues

Any proposed budgetary changes to member benefits shall be presented to the Board of Trustees as an agenda item, and not under the consent calendar, to allow for full discussion and decision. *(D)*

Approved MMS Board of Trustees, 9/21/22
(Accepted MMS House of Delegates, 12/10/22)

The MMS will develop a plan to expand, and where appropriate handle confidentially, the demographics voluntarily provided by our members to include both sexual orientation and gender identity. *(D)*

MMS House of Delegates, 4/28/18

The MMS will obtain secure and confidential race and ethnicity data for MMS members by utilizing all available sources, including third-party vendors, in order to understand the current composition of the MMS membership, and assist in the development of future goals. *(D)*

MMS House of Delegates, 12/3/16
Reaffirmed MMS House of Delegates, 5/13/23

The MMS approves the waiver of membership dues for all medical school graduates that are eligible to apply for a graduate medical education program in the U.S. and who reside in Massachusetts and who have not been accepted into an accredited graduate medical education program. The approval for the waiver will be based on the request from the physician that shall be submitted annually, and is eligible for a period of up to five years after medical school graduation. The member status will change when a physician enters an accredited graduate medical education program. *(HP)*

MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS will work with the district medical societies to initiate consistent discounts for both state and district dues, which would provide simplification of the billing process and deliver more comprehensive invoices to the member. *(D)*

MMS House of Delegates, 5/21/11
(Item 1 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 5/11/13)
Reaffirmed MMS House of Delegates, 4/28/18

The MMS will continue to seek to expand the diversity of its membership and member participation in its activities. *(D)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS reinforces that its Code of Ethics is a standard of Society membership. *(D)*

MMS House of Delegates, 11/15/08
*(*for additional information, please see Informational Report: A-09 – 29, from the Task Force on Code of Ethics as a Standard)*
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society exempts dues for residents who enroll as part of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency training programs. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates 5/21/22

The Massachusetts Medical Society (MMS) will exempt dues for its Medical Student Membership. *(D)*

In order to offset expenses of exempt dues for Medical Student Membership, an alternative level of benefits will be provided for medical student members, including substitution of the *New England Journal of Medicine* (NEJM) *Online* for the printed NEJM subscription, and that medical students will no longer have MMS Internet account privileges. *(D)*

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

The MMS shall continue its efforts to further enhance its image with key constituencies, including patients and physicians. *(HP)*

The MMS shall continue working with the American Medical Association (AMA) to build AMA membership and to enhance the image of organized medicine in Massachusetts. *(HP)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

The MMS will institute the following initiatives to encourage large group practice and other health care organization physicians to become members:

- Identify current MMS members in large group practices and other health care organizations to serve as "in-house" recruiters and establish on-going recruitment programs within each entity.
- Work with the administrations of large group practices and other health care organizations to provide newly-hired physicians with MMS membership information, as well as ensuring that membership recruitment materials are available to all physicians within these entities.
- Work to ensure that there are regular opportunities for MMS representatives to make membership presentations to the staffs of large group practices and other health care organizations.

- Recruit group practice and other health care organization physician representatives to serve as members of the MMS Organized Medical Staff Section and ensure their active involvement.

(D)

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
(Bullet 3 and 5 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/4/19

The House of Delegates delegates to the Board of Trustees the authority to approve the use of pilot membership recruitment/retention projects involving variations of no more than 50% on the current MMS dues structure, as proposed by the Committee on Membership. *(D)*

Such pilot projects shall be required to have a defined time limit, as well as having the prior approval of the Committee on Finance. *(HP)*

The Committee on Membership shall report annually to the House of Delegates as to the impact of all current pilot projects. *(D)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

NEJM Group

The Delegates affirm that their Committee on Publications and the leadership of the Society continue to use due diligence in avoiding inappropriate commercial arrangements that might damage the professional reputation of the Society, *The New England Journal of Medicine*, or the Society's other publications. (HP)

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Editor-in-Chief of *The New England Journal of Medicine* (NEJM) and the Editor-in-Chief, NEJM Group, in stewardship of NEJM Group products and publications, shall continue to enjoy complete editorial independence. *(HP)*

Any print or electronic product or publication entitled *The New England Journal of Medicine,* having "NEJM" in its title, or identified as coming from the editors of *The New England Journal of Medicine* shall fall under the responsibility of the Editor-in Chief, NEJM Group. *(HP)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The following vision statement shall guide the Massachusetts Medical Society (MMS) publishing activities:
The MMS will continue to be a leader in publishing authoritative information on health care and health sciences. Through its Committee on Publications and Publishing Division, the Society will "…do all things as may be necessary and appropriate to advance medical knowledge…" as first defined in its Act of Incorporation (Chapter 15, of the Acts of 1781, as amended). The Society will maintain the recognized level of excellence and credibility of its publications in the scientific, medical, and public domains throughout the world.

The principal objectives of its publishing activities are to advance biomedical science and to educate physicians, other healthcare professionals, and the public. The NEJM and MMS further affirm the importance of addressing health equity and the elimination of racism in medicine. New developments will be encouraged in response to changes in educational and scientific needs and the availability of new publishing technologies. This will be accomplished in a manner that advances biomedical science and upholds the integrity and financial ability of the Massachusetts Medical Society to carry

out its mission. The Society will conduct its publishing activities in a supportive, collaborative, and fully inclusive environment.

MMS will protect the editorial freedom and independence of all its NEJM Group products and publications. The Society will continue to pursue its mission with an abiding commitment to maintaining the excellence and preeminence of *The New England Journal of Medicine* and NEJM Group products and publications.
(HP)

The MMS House of Delegates shall review and affirm the publishing vision statement annually as prepared by the Committee on Publications. *(D)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Delegates express their continued confidence in the integrity and judgment of the Committee on Publications, the Board of Trustees, and the Society's Officers, and recommend that the Society continue appropriate policy with respect to new publishing and medical information ventures commensurate with the Society's resources and committee structure.
(HP)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 5/21/22

Physician Health Services
The MMS strongly emphasize to its members the very important work Physician Health Services (PHS) does and highlight the fact that PHS is supported largely by charitable donations. *(D)*

MMS House of Delegates, 12/6/14
Reaffirmed MMS House of Delegates, 5/8/21

The House of Delegates votes to increase the Board of Trustees' role as sole voting member with respect to Physician Health Services, Inc.

The House of Delegates votes to delegate to the Board of Trustees the authority to act for and on behalf of the Massachusetts Medical Society in its capacity as sole voting member of Physician Health Services, Inc., in all matters which, by law, the Articles of Organization of Physician Health Services, Inc., or the bylaws thereof require action by the sole voting member, including, but not limited to amendment of the said Articles or bylaws, except that such delegation of authority shall not be construed as extending any power which the House of Delegates is prohibited from delegating and provided that the actions of the Board of Trustees in this capacity as sole voting member shall be reported to the House of Delegates.
(HP)

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Physician Writing Skills/Public Communications
Thee MMS will curate a toolkit of resources to be used by physicians and medical students interested in improving their skills at writing op-eds, letters to the editor, and other public communications. *(D)*

The MMS will develop an accredited online educational activity to teach physicians writing skills for op-eds, letters to the editor, and other public communications with the goal of increasing the number of published physician-authored media commentaries. *(D)*

The MMS will collaborate with its member specialty societies and MMS sections, committees, and House of Delegates to identify and bring together a diverse group of physicians and medical students interested in writing op-eds, letters to the editor, and other public communications to advance community and stakeholder understanding of issues concerning patient, physician, health system, and social determinants of health. *(D)*

MMS House of Delegates, 5/13/23

Policy Regarding Respectful Behavior

Policy Regarding Respectful Behavior

POLICY
It is the policy of the Massachusetts Medical Society that all participants in MMS meetings, events, and activities are expected to exhibit respectful, professional, and collegial behavior during such meetings, events, and activities, including but not limited to committee meetings, House of Delegates meetings, dinners, receptions, and social gatherings. Attendees/participants should exercise consideration and respect in their speech and actions, including while making formal presentations to other attendees, and should be mindful of their surroundings and fellow participants.

The MMS will not tolerate language or behavior that demeans a guest, participant, or attendee on the basis of race, ethnicity, nationality, age, gender, creed, religion, sexual orientation, gender identity, gender expression, disability, economic status, or other similar identifier.

Demeaning language and behavior are that which a reasonable person in the same or similar circumstances as the person being described would feel adversely affects their participation in the meeting, event, or activity. Such language and behavior include, but are not limited to epithets, slurs, or negative stereotyping; threatening, intimidating, or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is visible during an MMS meeting, event, or activity.

As a condition of attending and participating in any MMS meeting, activity, or event, each attendee will be required to acknowledge and accept (i) this policy and (ii) applicable adjudication and disciplinary processes for violations of this policy. All attendees are expected to conduct themselves in accordance with this policy.

Additionally, individuals elected or appointed to a leadership role in the MMS or its affiliates will be required to acknowledge and accept this policy and related procedures. *(HP)*

MMS House of Delegates, 12/4/21

Policy Resources and Tracking
The MMS Board of Trustees or its designated agents will develop an informational report that would be presented at each House of Delegates meeting that:

a. Those reports and resolutions that thus far are not funded or partially so
b. Stands alone as a report with an appropriate title, which is not to be contained within a more lengthy report (e.g., the budget)
c. Updates prior such nonfunded or partially funded reports and resolutions
d. Supplies the links or hyperlinks to the entire verbiage of above-mentioned reports or resolutions to ensure the responsibility of the House of Delegates to restudy the appropriateness and support of these decisions
e. Includes the reasoning (financial, legislative, etc.) for this status and decision. *(D)*

MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Sections
The Massachusetts Medical Society will reimburse medical student and resident members a reasonable amount for travel that pertains to official Massachusetts Medical Society business, particularly for travel to and from committee meetings (and the like) of which the student or resident is a member. *(HP)*

The medical student and resident reimbursement for travel be an appropriate amount for miles traveled, tolls, and (reasonable) parking fees. *(HP)*

Medical student and resident reimbursement for travel not imply indemnification for motor vehicle accidents. *(HP)*

The Board of Trustees shall be charged with the establishment of criteria for medical student and resident reimbursement of travel. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Strategic Direction
The Massachusetts Medical Society (MMS) reaffirms the purposes of the Society as outlined in Section 2 of the Act of Incorporation of the MMS, Commonwealth of Massachusetts, Chapter 15 of the Acts of 1781 as amended in 1969, which reads as follows:

> The purposes of the MMS shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit and welfare of the citizens of the Commonwealth.

(HP)

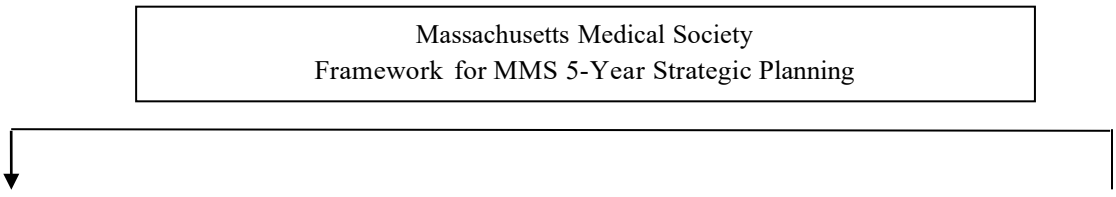
The MMS reaffirms the statement of strategic direction for the Society adopted by the House of Delegates on November 6, 1996 which reads as follows:

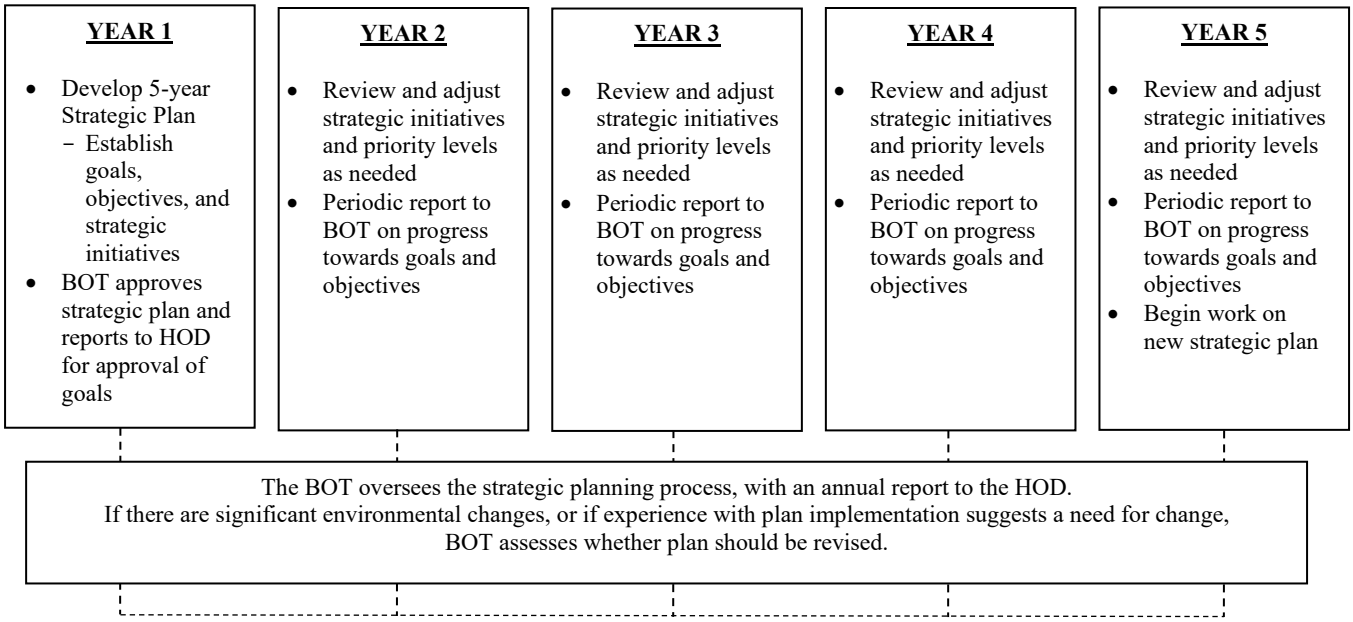
> The Massachusetts Medical Society will continue to be a proactive organization. We will advocate for the shared interests of patients and our profession. We seek to unite all physicians and serve the common interests of the profession. Our goals are to enhance and protect the physician-patient relationship and to preserve the physician's ability to make clinical decisions for the benefit of patients. The Society will continue to encourage the development of standards for high quality care. We will continue to promote our code of ethics to physicians, patients, and the public. We will work collaboratively within the profession and with the public. The Society will address the professional needs of physicians and take a leadership role in the development of health care policy. We will promote medical education, training, research, and the continuing education of physicians. We will communicate clearly and effectively with our members and the public to build awareness of and support for our goals.

(HP)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
(Item 2 of Original (statement of strategic vision) –Sunset/Adopted in lieu of MMS House of Delegates, 5/4/19)

The Massachusetts Medical Society's strategic planning process is adopted as amended to focus on the establishment of a five-year strategic plan instead of a one-year plan and a three-year plan, with an annual review of progress towards achievement of the goals and objectives associated with the plan, as reflected in the "Proposed Framework for MMS 5-Year Strategic Planning" diagram below. *(HP)*





The MMS describes the characteristics of the desired future state for Massachusetts' physicians and what would constitute success for the MMS by adopting the following statement for its current strategic vision:

The Massachusetts Medical Society (MMS), the professional association for all physicians in the Commonwealth of Massachusetts, is the most trusted and respected leadership voice in health care, advancing medical knowledge and the medical profession to improve patient care and outcomes. We are a proactive organization that advocates for the shared interests of patients and our profession and takes a leadership role in the development of health care policy. We enhance and protect the physician-patient relationship and preserve the physician's ability to make clinical decisions for the benefit of patients. We encourage the development of standards for high-quality care, and promote medical education, training, research, and the continuing education of physicians. *(HP)*

That, in order to advance the Society's mission and prepare for the future needs of the physician community and their patients, the goals of the Massachusetts Medical Society's strategic plan for Fiscal Years 2020–2024 will be the following, unless adjusted through the annual review process:

Goal A: Patients
All people will achieve optimal health and wellbeing through patient engagement and improved health literacy, and equal access to timely, comprehensive, affordable, high-quality, integrated health care throughout their lives.

Goal B: Physicians
Physicians will enjoy a satisfying career in medicine that is grounded in high-quality care, intellectual growth, and financial sustainability in an inclusive environment with minimal regulatory burden.

Goal C: The Massachusetts Medical Society
The MMS will be the most trusted and respected leadership voice in health care, advancing medical knowledge and the medical profession to improve patient care and outcomes, maintaining a sound financial position and a diverse, engaged, and expanding membership.
(HP)

MMS House of Delegates, 5/4/19

Structure/Governance
The MMS will examine, with appropriate external expert consultants, alternative approaches to structure and governance and associated financial considerations of the entire organization and its divisions. *(D)*

The MMS will develop a process that is effective, transparent, and inclusive to examine alternative approaches to structure and governance and associated financial considerations of the Society. *(D)*

The progress on an examination of alternative approaches to structure and governance and associated financial considerations of the Society will be reported back to each session of the House of Delegates. *(D)*

MMS House of Delegates, 12/5/20

Volunteer Vouchers
Volunteer vouchers for MMS-sponsored educational programs will be allowed to roll over for two fiscal years. *(D)*

MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

MEDICAID

Continuation of
The Massachusetts Medical Society recognizes the importance of Medicaid to covering our Commonwealth's children, disadvantaged, and disabled. *(HP)*

The Massachusetts Medical Society supports the continuation of Medicaid as a federal entitlement. *(HP)*

MMS House of Delegates, 4/29/17

Eligibility Criteria and Enrollment
The Massachusetts Medical Society (MMS) will advocate for maintaining and improving health care coverage for certain groups of individuals in this state through initiatives, including, but not limited to:

- Continuing aggressive outreach programs to ensure 100 percent health care coverage for the children of Massachusetts
- Assuring that enrollment criteria for Medicaid remain at the highest eligibility level that allows for federal financial participation, and to continue the broadest possible inclusion of participants

(D)

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Item 2 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

MassHealth Program
The MMS will advocate for legislation in Massachusetts to require the state's Medicaid program, MassHealth, to institute pay parity, requiring Medicaid rates to remain at least as high as Medicare rates for the same services. *(D)*

MMS House of Delegates, 12/5/15
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society will work with the Massachusetts Division of Medical Assistance (MassHealth) to revisit the MassHealth drug list and prior authorization process so that patient well-being is not compromised. *(D)*

MMS House of Delegates, 11/8/03
MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Preauthorizations
The Massachusetts Medical Society recommends to the Division of Medical Assistance that any requirements for preauthorizations by physicians be reviewed by MMS prior to implementation. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Amended and Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Sterilization
The Massachusetts Medical Society supports and works to achieve the right of men and women in the MassHealth program to a reasonable waiting time between consent and procedure for sterilization, and that they be accorded the same autonomy as privately insured individuals. *(HP)*

MMS House of Delegates, 11/6/00

Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

MEDICAL EDUCATION

Accreditation Council for Continuing Medical Education (ACCME)
That the Massachusetts Medical Society adopts the Accreditation Council for Continuing Medical Education Accreditation Criteria and policies, as amended from time to time, as a means to ensure that accredited continuing education contributes to patient safety and practice improvement, is based on valid content, and is independent of commercial influence. *(HP)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society adopts the Accreditation Council for Continuing Medical Education (ACCME)'s Accreditation Criteria and policies that include the Standards for Commercial Support: Standards to Ensure Independence in CME Activities[SM] as amended from time to time, as a means to develop high-quality continuing medical education activities that are relevant, promote improvements in health care, and are independent of commercial influence. *(HP)*
MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Amended and Reaffirmed MMS House of Delegates, 12/7/19

Care for Persons with Intellectual Disability/Developmental Disability
The MMS will provide appropriate continuing medical education opportunities that address medical care of persons with Intellectual Disability/Developmental Disability (ID/DD) and will be accessed voluntarily by MMS members. *(D)*

The MMS will provide web-based information to MMS members on resources and reference information on medical care of persons with ID/DD. *(D)*

MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Diversity in Accredited Continuing Education Activities
The MMS will remain committed to ensuring that its accredited continuing education activities are diverse, accessible, inclusive, and culturally responsive in all facets of education, including but not limited to their pedagogy, content areas, adjunct materials, and professional development, for its offerings to all members of the Massachusetts physician community. *(HP)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Educational Debt
The MMS will pursue the following in regard to educational debt reduction:
- Support government funded student loan forgiveness programs for physicians and medical students
- Advocate for other lenders' constructive revision of loan repayment terms, such as income-contingent loan programs
- Support any legislative effort to prolong the deferment period for educational loans through residency and fellowship
- Support legislative efforts to alter the eligibility requirements for allowing interest from educational loans to be an income tax deduction from a flat-income level to a ratio of debt to income

(D)

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 2-3 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Graduate Medical Education
The MMS will continue its efforts to secure Graduate Medical Education (GME) funding through our Congressional Delegation and coordinate those efforts with the American Medical Association. *(D)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society (MMS) establishes as policy its position that all physicians and medical students should be evaluated for the purpose of entry into graduate medical education (GME) programs, licensure, and hospital medical staff privileges solely on the basis of their individual qualifications, skills, and character. *(HP)*

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

LGBTQ Research Scholarship
The Massachusetts Medical Society encourages all medical schools in Massachusetts to consider the recommendations released by the Association of American Medical Colleges (AAMC) Group on Student Affairs (GSA), the AAMC Organization of Student Representatives (OSR), and American Medical Association policy and address areas in their curricula that require updating to meet these recommendations relative to incorporating lesbian, gay, bisexual, and transgender (LGBT) student and patient needs. *(HP)*

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

The Massachusetts Medical Society (MMS) will offer annually a scholarship related to lesbian, gay, bisexual, transgender, and queer (LGBTQ) matters (The LGBTQ Research Scholarship) made eligible to the medical schools and specialty training programs in the Commonwealth. The scholarships may be used for curriculum development or to produce research that address lesbian, gay, bisexual, transgender, queer health services, health outcomes, and health disparities.

The LGBTQ Research Scholarship recipients will be required to present the outcomes of their efforts at the subsequent MMS Interim Meeting.
(D)

MMS House of Delegates, 5/4/19

Patients and Work Disabilities
The MMS is an advocate for the need for effective care-delivery strategies that aim to enhance function and well-being for patients challenged by chronic health conditions while minimizing work disability. *(HP)*

The MMS will develop an online activity to educate physicians on coaching strategies to maximize vocational success for patients with work disabilities. *(D)*

MMS House of Delegates, 4/28/18

State-Funded Medical School
The Massachusetts Medical Society (MMS) recognizes the importance of having a state-funded medical school in Massachusetts to provide a high-quality, but lower-cost option for residents of the Commonwealth to obtain a medical education. *(HP)*

The MMS strongly urges the Governor and the Massachusetts Legislature to maintain the University of Massachusetts Medical School's status as a public institution supported in part by state funding. *(HP)*

MMS House of Delegates, 5/2/03
(Item 2 of Original: Time-Limited Directive Completed MMS House of Delegates, 11/8/04)
MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

MEDICAL RECORDS/ELECTRONIC HEALTH RECORDS *(Please see additional policy under Health care Delivery, Discharge Planning Process)*

Clinical Data Repositories

A: The MMS adopts the following as Principles for Clinical Data Repositories (CDRs):

Clinical Data Repositories (CDRs) are beneficial for patients and physicians to improve the quality, safety, efficiency, and value of medical care for all patients. The development and use of CDRs — following the appropriate privacy and security regulations — should be embraced and encouraged.

The Society should seek to bring the benefits of CDRs to physicians across the state, including primary care physicians and specialists in solo practice, small groups, and large groups.

Massachusetts benefits from the continued collaboration of public and private organizations — such as the MMS, Massachusetts Hospital Association, Massachusetts Health Quality Partners, Massachusetts Health Data Consortium, Massachusetts Technology Collaborative, commercial payers, and MassHealth — to build the information infrastructure for our health care system. CDRs form a part of that continuum of development. Massachusetts' all-payer claims database overseen by the Center for Health Information and Analysis, has valuable information to inform policy development and help improve outcomes.

The Society should encourage public and private organizations to share data to enable CDR deployment and to enable the comparison of outcomes and processes among physician groups and patient populations.

Adoption of common data standards and definition of important clinical outcomes at the state and national level are ongoing processes necessary to achieve maximum value of CDRs for all constituencies.
(D)

MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
**(Item B5 of Original: Sunset)*
(Complete Item B of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society (MMS) will collaborate with appropriate business partners to evaluate the feasibility of providing a supportive framework to assist physicians in dealing with data repositories containing quality information to improve the practice of medicine. Evaluation will include the following:

Inventory and study how current and planned clinical data repositories can assist physicians in the care and treatment of patients, guided by our AMA/MMS Privacy and Confidentiality policies, as well as regulations promulgated under HIPAA and applicable state statutes.

Evaluate and study clinical repositories with the additional goal of assisting physicians in understanding their own "report cards," benchmarks, and other reports that easily highlight "opportunities for improvement," based on MMS/AMA-approved, evidence-based standards.
(D)

The MMS will evaluate funding resources that might be available to physicians to better understand the use of clinical data repositories and data warehouses. *(D)*

The MMS will encourage collaboration between the MMS and organizations developing repositories to ensure accuracy, transparency of algorithms, scalability, and interoperability features that facilitate use in the many and varied settings where physicians practice. *(D)*

The MMS will promote clinical data repository features (standards-based data exchange, ease of use, clinically relevant reports) that support the dissemination of interoperable electronic medical records that promote and enhance the physician-patient relationship, in concert with other local and national efforts. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
(Item 5 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society will work with appropriate organizations (including the American Medical Association, specialty societies, and patient advocacy groups) to ensure that the clinical data-exchange standards on which a National Health Information Network and Regional Health Information Organizations are based are subject to approval and ratification by these organizations and end-users such as physicians and patients. *(D)*

MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

The MMS will work with appropriate entities to improve the functionality and value of EMRs for physicians and their patients, with the goal of enhancing health care quality, safety, equity, and efficiency. *(D)*

MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
(Items 1 and 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The MMS will research and develop clear guidelines, best practices, and ongoing education regarding the effective use of electronic health records (EHR)/health information exchange (HIE) technologies based on appropriate information.

Subjects should include but not be limited to:
- Analysis of time management before and after EHR adoption
- Quality of practice after EHR implementation
- Amount of time required to complete a high-quality medical record per patient
- Guidelines for preparing effective and appropriate notes for primary care and specialists using technology tools
- Reimbursement before and after use of an EHR
- The effects of various reimbursement models on electronic workflow
- Quality of practice before and after EHR implementation
- Utility of employing medical scribes
- Confidence in coding using an EHR
- Use of templates and whether information is truly entered because of its importance to patient care versus its importance to complying with billing and coding mandates
- The use of "pertinent negatives" and the amount of data that is carried forward to save time and improve coding, but in fact is not addressed at the time of the visit
- Legal and liability issues surrounding the exchange of protected health information (PHI)
- Guidelines for communicating electronically with patients
- Physician suggestions for EHR technology improvement
- Effects of coding on the usability of both entering and reading and usefulness of EHRs
- Experience with free and low-cost cloud EHRs such as the VA VistA system, and explore the benefits, risks, availability, and usability of open source EHRs.
- Best practices for managing patient privacy, opt-in, and obtaining records.

(D)

The results of the research on electronic health records and health information exchange will be distributed widelyusing low-cost electronic means. *(D)*

MMS House of Delegates, 12/1/12
Reaffirmed MMS House of Delegates, 5/4/19

Electronic Medical Records Impact on Health Care System
The MMS will work concurrently with the AMA and encourage the AMA to work with relevant stakeholders, including medical staffs and community physicians, to monitor the current and projected fiscal impact of electronic medical record (EMR) implementation nationally, and in Massachusetts in particular, on the health care system including the potential impact on recruitment and retention of the physician and health care workforce, population health, cost and quality of patient care, and access to patient care and report back on this study at A-19. *(D)*

The MMS will work, and encourage the AMA to work, to distribute to medical staffs and community physicians the information on the current and projected fiscal impact of EMR implementation on the health care systems to educate and encourage their participation in medical staff issues, and work closely with hospital administration on the downstream financial impact of large capital expenditures such as EMRs. *(D)*

MMS House of Delegates, 4/28/18

Medical Information: Transmission to Treatment Team
The MMS will work to educate appropriate entities (e.g., medical staffs, hospitals, hospital associations, medical specialty societies) regarding application of the HIPAA rules that assist the transfer of information to the members of a patient's treatment team without written authorization. *(D)*

The MMS will develop model procedures and template releases to facilitate the speedy transmission of relevant medical information to any member of the patient's treatment team, as allowed by HIPAA, regardless of the provider's location. *(D)*

MMS House of Delegates, 12/2/17

OpenNotes Movement
The MMS supports the general proposition that patients should have access to their medical notes from their medical records via patient portals or other cost-effective means, but acknowledges that such access may not always be appropriate. *(HP)*

The MMS shall monitor the OpenNotes movement (i.e. which urges doctors, nurses and other health care professionals to share the medical notes with their patients) and keep members updated on its progress. *(D)*

MMS House of Delegates, 4/28/18

The MMS will explore ways to help our members own and share aggregated practice performance data to include claims-based and clinical information. *(D)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 1 and 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/8/21

Prescription Drug Monitoring Program
The Massachusetts Medical Society will advocate, at the state and national levels, to promote prescription drug monitoring program (PDMP or PMP) integration/access within electronic health record workflows (of all developers/vendors) at no cost to the physician or other authorized health care provider. *(D)*

MMS House of Delegates, 5/4/19

MEDICARE/MEDICAID SERVICES

Funding
The MMS supports appropriate tax policy to ensure that Medicare is adequately funded. *(HP)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/7/16
(Items 1 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/13/23

MassHealth
The MMS reaffirms the primacy of the patient-physician and behavioral health-mental health relationship. *(HP)*

The MMS will expeditiously request that MassHealth or other relevant state agencies recognize the importance of patient-physician continuity of care and honor all pre-existing patient-physician and behavioral health-mental health relationships. *(D)*

The MMS will continue to engage MassHealth or other relevant state agencies to craft directives and policies that support and foster established patient-physician and behavioral health-mental health relationships. *(D)*
The MMS will request that MassHealth develop measurement tools to assess the impact of the current accountable care organization implementation, particularly in regard to the effect that disruption of patient-physician and behavioral health-mental health relationships has on health status and overall health care costs. *(D)*

MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) will encourage appropriate government entities to ensure that, consistent with the intent of federal law, the Medicare fee schedule be an absolute minimum floor for services provided to MassHealth patients. *(HP)*

The MMS encourages adequate medication coverage for MassHealth patients that does not interfere or intrude on the doctor-patient relationship when reasonable clinical documentation of medical necessity is provided. *(HP)*

MMS House of Delegates, 12/5/09
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Practice Expenses
HCFA [CMS] should make efforts to broadly survey medical practices for actual expense data. *(HP)*

The complex surveys needed for practice expense determination should be funded, reimbursing contributing practices for their time and effort. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

NURSES AND NURSING

The Massachusetts Medical Society (MMS) acknowledges the essential role of nurses in the overall care of patients. *(HP)*

The MMS recognizes that there is a shortage of professional bedside nursing services. *(HP)*

The MMS supports the efforts of the nursing profession in Massachusetts to attract well-qualified diverse candidates for nursing education programs. *(HP)*

The MMS urges hospitals and other health care settings to provide clinical education opportunities for nursing students. *(HP)*

The MMS urges physicians to cooperate and participate in in-service training programs for nurses. *(HP)*

The MMS urges hospitals, when assigning nurses, to prominently consider diversity, training and expertise as well as appropriate nurse to patient ratios. *(HP)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

PHYSICIAN PAYMENT

Capitation

a. The Massachusetts Medical Society (MMS) supports physicians' right to contract directly with payers and/or employers to obtain payment for services. *(HP)*

b. The MMS opposes the imposition of capitation and/or bundled payments on physicians and groups that state they are not ready to do so. The MMS insists that the decision to accept capitation and/or bundled payments be voluntary and self-determined by said physicians and groups based on their financial assessments and clinical integration competencies. *(HP)*

c. The MMS strongly recommends that organizations that take downside risk arrangements, including capitation, must also purchase appropriate stop-loss insurance and other appropriate tools to mitigate substantial risk. *(HP)*

d. The MMS opposes any activity on the part of government or insurance companies that decreases payments to physicians or increases cost sharing to patients as incentives to accept capitation and/or bundled payments. *(HP)*

e. The MMS will use its resources to oppose elimination of fee-for-service medicine. *(D)*

f. The MMS will publicly promote the high quality of medical care in Massachusetts and educate the public and out public officials that many of the benefits of high quality health care measures, such as prevention, screening, chronic disease management, electronic health records and wellness programs, improve care and produce value. *(HP)*

The MMS opposes price and growth caps on physicians and physician organizations and instead supports the many alternative reform options to limit growth in health care spending, including establishing a statewide cost growth goal, development of health and cost outcomes scorecards (such as the Comprehensive Health Impact Assessments (CHIA) and the Health Policy Commission reports), growth in alternative payment models that are adequately funded, improved price transparency, integration of behavioral health and primary care, expansion of tele-health, decreasing unnecessary emergency room use and avoidable readmissions, and using the American Board of Internal Medicine's Choosing Wisely© program as an opportunity for improvement. *(HP)*

MMS House of Delegates, 12/5/09
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Claims Processing

Our Massachusetts Medical Society will advocate to third-party payers that a medical peer should be available as part of the appeals process for claims payment rejection or reduction based on diagnosis and coding payment rules, as well as other non-administrative issues, should a physician request such review. *(D)*

MMS House of Delegates, 5/8/21

The MMS will continue to advocate for reimbursement for all physicians' services as reflected in the AMA's Current Procedural Terminology codebook. *(D)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Item 1 of Original Sunset, MMS House of Delegates, 4/28/18
Item 2 of Original Reaffirmed MMS House of Delegates, 4/28/18

Creation of Physicians' Associations
The MMS shall increase advocacy on behalf of individual members. *(D)*

The MMS shall educate members regarding alternative practice arrangements. *(D)*

The MMS supports changes in federal law to permit independent contractor physicians to engage in collective bargaining. *(HP)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Fee-for-Time/Locum Tenens
The MMS will advocate for Massachusetts health plans to accept the use of the fee-for-time compensation arrangements (previously termed locum tenens) and, if necessary, expedite credentialing for locum tenens physicians to secure continuous coverage and payment. *(D)*

The MMS will encourage transparency with patients when a practice uses fee-for-time compensation arrangements. *(D)*
(Approved MMS Board of Trustees, 11/1/23)
Accepted MMS House of Delegates, 12/9/23

Physician-Led Team-Based Health Care
The Massachusetts Medical Society adopts the following adapted from American Medical Association policies:

The MMS will encourage independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks, or other networks of independent providers. *(D)*

The MMS will encourage public and private health insurers to develop and offer a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care. *(D)*

The MMS will encourage the Centers for Medicare and Medicaid Services to ensure that Medicare Alternative Payment Models do not require physicians to assume responsibility for costs that they cannot control. *(D)*

The MMS will continue to actively advocate to the Centers for Medicare and Medicaid Services that physicians in all specialties and modes of practice must have at least one Medicare Alternative Payment Model in which they can feasibly participate. *(D)*

The MMS will advocate to the Centers for Medicare and Medicaid Services that any review process of alternative payment models proposed by stakeholders be completed in a timely manner include an administratively simple appeals process and access to an ombudsman. *(D)*

MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Recoupment Limitations
The MMS will immediately draft legislation that establishes a time limit for recoupment of payments which is equal to the time limit that is established by each payer for the submission of claims, only excepting demonstrably fraudulent or criminal activities and actively seek to have this legislation filed. *(D)*

MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 4/28/18

When notified of an overpayment on a claim, the insurance company cannot perform automatic recoupments. *(HP)*

Physicians, when notified, will have 35 days to contest the overpayment before payment is due. *(HP)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09

(Item 1 and bullets 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Resource Based Relative Value Scale (RBRVS)
The Massachusetts Medical Society urges the American Medical Association to advocate to the Centers for Medicare and Medicaid Services [CMS] that any federal statutory or regulatory mandate(s) implemented after January 1, 1992 simultaneously include the practice costs associated with the mandate(s) in the practice cost component of the Medicare RBRVS payment system. Said increase(s) in the practice cost component shall not be taken into consideration in determining compliance with budget neutrality; that the Massachusetts Medical Society urge the American Medical Association and its federation members to advocate to [CMS] and state officials that any federal or state mandate(s) implemented after January 1, 1992 simultaneously include the practice costs associated with the mandate(s) in Medicaid rates of payment to physicians. Said increase(s) in rates shall not be taken into consideration in determining compliance with budget neutrality; that the Massachusetts Medical Society encourage its members and sister organizations to urge their members to communicate their concerns about timely recoupment of practice cost and other health care cost increases associated with federal mandates to the President, [CMS] and the Congress. *(HP/D)*

MMS Council, 5/14/93
Reaffirmed MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Stark Law
The Massachusetts Medical Society will oppose and advocate against the misuse of the Stark Law to cap or control physician compensation. *(D/HP)*

MMS House of Delegates, 4/28/17
(Items 1-3 of Original: Auto-Sunset; Time-Limited Directives to Complete by 2018, MMS House of Delegates, 4/28/18)

Supervising Teaching Physicians
The Massachusetts Medical Society advocates that all payors reimburse the supervising teaching physician for services provided by a resident unless that resident's service is already fully and explicitly funded by that payor. *(HP)*

MMS House of Delegates, 5/16/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Supervision of Advanced Practices Nurses and Physician Assistants
The Massachusetts Medical Society will introduce and support legislation requiring that MassHealth will recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by paying the physicians for services, and especially for supervision, of APNs and PAs, equal to 100% of the physician's reimbursement rate. *(D)*

The Massachusetts Medical Society will encourage all payers to recognize the value of physician supervision of advanced practice nurses (APNs) and physician assistants (PAs), within a physician-led team-based practice, by continuing to pay for services, and supervision, of APNs and PAs equal to 100% of the physician's reimbursement rate. *(D)*

(Approved MMS Board of Trustees, 10/11/17)
Accepted, MMS House of Delegates, 12/2/17

Third-Party Insurers
The Massachusetts Medical Society will work with the state legislature and the Massachusetts Division of Insurance to ensure that if a claim is defective, then a third-party payer will notify providers within fifteen days of receipt of the claim as to the nature of the defect. *(D)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or directives for all insurance carriers, including Medicaid and Medicare, to pay for mandated services required by law or regulation. *(D)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society will advocate to payers and support legislation to require payment to physicians and other health care providers for services rendered if — at the time of the patient's visit — the provider verified coverage through the insurer's available eligibility inquiry system(s), regardless of: future retroactive eligibility changes by the employer or patient, or errors in the insurer's eligibility system. *(D)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians' ability to meet administrative requirements. *(D)*

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:

(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer's remittance advice;
(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information;
(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change; and
(e) the submission of claim that was hindered by unforeseen circumstances.

(D)

The MMS will monitor health plans' adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. *(D)*

The MMS will continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. *(D)*

The MMS will advocate for a clearly stated and accessible appeals process for claims denied based on time limitations of submissions. *(D)*

MMS House of Delegates, 11/9/02
Amended and Reaffirmed MMS House of Delegates, 11/8/03
Reaffirmed (and Item 1 Amended and Reaffirmed) MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or directives for all insurance carriers, including Medicaid and Medicare, to pay for mandated services required by law or regulation. *(D)*

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

PHYSICIANS

Collegiality/Member Activities

The Massachusetts Medical Society will create, maintain, and grow a repository for MMS members of potential activities for group experiences to facilitate medical community members and families sharing in collegial activities. *(D)*

MMS House of Delegates, 12/1/18

The Massachusetts Medical Society (MMS) will promote activities for improving collegiality among physicians. *(D)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Disabled Physicians

The MMS will study and report back on progress at A20 on means/mechanisms to reduce stigmatization and enhance inclusion of disabled physicians including but not limited to:

1) Enhancing representation of disabled physicians within the MMS.
2) Identifying support groups, education, legal resources, and any other means to increase the inclusion of physicians with disabilities in the MMS. *(D)*

The MMS will identify medical, professional, and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services, and other services which could assist disabled physicians to develop their capabilities and skills to their individual maximum and will hasten the processes of their individual social and professional integration or reintegration. *(D)*

MMS House of Delegates, 5/4/19

Gender Parity/Women in Medicine *(Please See Additional Policies under MMS Administration and Management)*

The MMS will distribute a no cost survey via email to MMS members to identify specific drivers of stress across demographic groups and to develop supportive infrastructures. *(D)*

The MMS will promote existing resources about gender equity in medicine by creating a webpage, and distributing the email link to the page. *(D)*

The Massachusetts Medical Society will advocate for national, institutional, and academic policies that mitigate gender disparities in pay and academic advancement, especially during a pandemic such as COVID-19. *(D)*

MMS House of Delegates, 5/8/21
(Item 1 of Original Auto-Sunset: Time-Limited Directive Completed MMS House of Delegates, 5/21/22)

The MMS will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers, and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting. *(D)*

The MMS will:

(a) Promote institutional, departmental, and practice policies, consistent with federal and Massachusetts law, that offer transparent criteria for initial and subsequent physician compensation;
(b) Continue to advocate for pay structures based on objective, gender-neutral criteria;
(c) Promote existing Attorney General guidance related to the Massachusetts Equal Pay Act, which offers a framework for to identifying gender pay disparities and guidance regarding appropriate compensation models and metrics for all Massachusetts employees; and
(d) Advocate for training to identify and mitigate implicit bias in compensation decision making for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement. *(D)*

The MMS will recommend as immediate actions to reduce gender bias to:

(a) Inform physicians about their rights under the: (i) Lilly Ledbetter Fair Pay Act, which restores protection against pay discrimination; and the (ii) Equal Pay Act, requiring, among other things, equal pay for comparable work, non-prohibition of voluntary wage disclosure to others, prohibitions on asking about salary history, and prohibitions on retaliating against employees who exercise their rights under the Act; and (iii) disseminate educational materials informing physicians about their rights under the Massachusetts Equal Pay Act;
(b) Promote educational programs to help empower physicians of all genders to negotiate equitable compensation; and
(c) Work with relevant stakeholders to develop and host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings. *(D)*

The MMS will collect and analyze comprehensive demographic data and produce a study on gender equity, including, but not limited to, membership; representation in the House of Delegates; reference committee makeup; and leadership positions within our MMS, including the Board of Trustees, Councils and Section governance, plenary speaker invitations (including, but not limited to, the Annual Meeting Education Program, the Annual Oration, and the Public Health Leadership Forum), recognition awards, and grant funding (including, but not limited to, grants from the MMS and Alliance Charitable Foundation); and disseminate such findings in regular reports to the House of Delegates, beginning at A-19 and continuing yearly thereafter, with recommendations to support ongoing gender equity efforts. *(D)*

The MMS will commit to the principles of pay equity across the organization and take steps aligned with this commitment. *(D)*

MMS House of Delegates, 12/1/18

The Massachusetts Medical Society endorses the American Medical Association's policy, "Gender Disparities in Physician Income and Advancement" that reads as follows:

Gender Disparities in Physician Income and Advancement

1. That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;
2. That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;
3. That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;
4. That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and
5. That our AMA provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

(HP)

The MMS will advocate and raise awareness for gender parity, equal pay, and advancement as a fundamental professional standard to ensure equal opportunity within the medical profession in Massachusetts. *(D)*

MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

JC Standards

The Massachusetts Medical Society will:

- Communicate to the Joint Commission on Accreditation of Healthcare Organizations (JC) the concern regarding the unintended consequences of JCAHO's standards, and methods of communicating those standards to physicians
- Advocate with the JC for direct communication to physicians~~~~ organizations about standards to be adopted or modified, with at least six months available for open commentary and feedback
- Advocate that this communication be timely and that it occur in print media as well as through e-mail
- Advocate that JC accreditation standards be made available to any licensed physician without hindrance
- Advocate that the JC establish a process for any physician to provide feedback about JCAHO programs that affect that physician's practice

(D)

MMS House of Delegates, 5/12/06
Items 1-5 of Original 6: Reaffirmed MMS House of Delegates, 5/11/13
(Item 6 of Original 6 Bullets: Sunset)
Reaffirmed MMS House of Delegates, 12/5/20

Peer Review

The MMS continues to recognize the value of a peer review system for protection of patient care and the impact of potential medical peer review misuse on the physician workforce in Massachusetts. *(HP)*

Amended and Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

The MMS will publicize and promote its policies regarding standards of care, including ethical professional behavior, to the Massachusetts Board of Registration in Medicine and/or any other entity engaged in the evaluation of such professional standards. *(D)*

MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Item 2 of Original: Sunset, MMS House of Delegates, 5/13/23
Reaffirmed MMS House of Delegates, 5/13/23

Physician Call

MMS On-Call Principles:

The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME). The term on-call includes hours providing patient care as well as administrative duties and hours awaiting call.

1. The MMS opposes government regulation of physician work hours.
2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.
4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.
5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.
6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.
7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.
8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.

9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.
10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.
11. Payment of physicians to be on call should be viewed as a fee for service, unless otherwise contracted, and when offered to some, be extended to all individuals or groups, not restricted only to some specialties.

(HP)

The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. *(D)*

MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society will modify its model Medical Staff Bylaws, as necessary, to address emergency department call coverage policies. *(D)*
The MMS will explore ways in which to address the safety and equitability of specialty emergency department on call coverage by all institutions, with a special emphasis on underserved communities. *(D)*

MMS House of Delegates, 12/5/09
Amended and Reaffirmed MMS House of Delegates, 4/29/17
(Item 2 of Original: Auto-Sunset; Time-Limited Directive Completed, 4/28/18)

a. The MMS will advocate for a balance between necessitating physician on-call services and meeting the needs of the patient population. *(D)*

b. The MMS recognize that on-call services:
   - Vary by setting, region, and specialty, and therefore, cannot be so specific that they would explicitly dictate a physician's practice.
   - Should provide the physician with the flexibility to determine the direction of his or her career.
   - Should accommodate and balance appropriate time off in determining physician responsibility.

(HP)

(Items below adapted from AMA policy)

c. The Massachusetts Medical Society strongly encourage physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges or state licensure. *(HP)*
d. The Massachusetts Medical Society support the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees. *(HP)*
e. The Massachusetts Medical Society advocate that physician on-call coverage for emergency departments be guided by the following principles:

   a. The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.
   b. Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.
   c. The organization and function of on-call services should be determined through hospital policy and medical staff bylaws, and include methods for monitoring and assuring appropriate on-call performance.
   d. Hospital medical staff bylaws and emergency department policies regarding on-call physician's responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.
   e. Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.

f. Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.
g. Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.
h. The decision to operate or close an emergency department should be made jointly by the hospital and medical staff.
i. Emergency on-call compensation agreements should be transparent to all medical staff members.
j. Compensation for emergency call can be an effective tool to ensure adequate participation on hospital staffs and on emergency call.

(HP)

MMS House of Delegates, 5/08/09
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Physician Rating Websites
Recognizing the importance of patients having access to reliable information, the Massachusetts Medical Society believes it is essential for the hosts of relevant review websites to develop a transparent method to verify a physician-patient relationship, while also protecting patient privacy, before allowing public comments about physicians to be posted on their website. *(HP)*

A physician review website that is unable to develop a transparent method to verify a physician-patient relationship, while also protecting patient privacy, should prominently disclose that it has not verified the existence of a physician-patient relationship or accuracy of posted comments. *(HP)*

Review websites should allow physicians to respond to comments made on their sites in a HIPAA compliant manner. *(HP)*

MMS House of Delegates, 12/2/17

Practice Valuation in Divorce
The MMS will advocate for physician practice valuation in divorce be done at Fair Market Value, rather than Fair Value, as is consistent with federal statutes governing other transactions involving physician practices. *(D)*

MMS House of Delegates, 5/19/13
Reaffirmed MMS House of Delegates, 12/5/20

Practice Viability
The Massachusetts Medical Society will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice. *(D)*

The MMS will recommend to the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education, that they encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option. *(D)*

MMS House of Delegates, 5/6/14
Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society (MMS) will continue to explore ways to help recruit and retain primary care and specialty physicians into the Commonwealth of Massachusetts. *(D)*

MMS House of Delegates, 11/15/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
(Item 2 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society will work with the Commonwealth of Massachusetts to create incentives to encourage more physicians to continue practicing in Massachusetts. *(D)*

The MMS will work with all health care stakeholders to encourage active development of re-entry options for physicians who have taken time out from practice. *(D)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society will monitor the impact of hospital systems' expansion on community hospitals and physician practices and the ultimate cost and quality of health care. *(D)*

MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society shall continue its advocacy and outreach campaign to educate the public, purchasers, public officials and opinion leaders on the challenges facing physician practices; to express the need to cover rising costs in order to maintain practice viability; to secure proper allocation of premium to ensure patient care. *(D)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Principles on Medical Professional Review of Physicians
Principles on Medical Professional Review of Physicians

The Massachusetts Medical Society adopts the following amended Principles on Medical Professional Review of Physicians within Health Insurance Companies and Medical Professional Review of Physicians within Health Care Facilities.

These principles are separate from the model principles that apply to medical peer review of physicians for health care facilities. The following principles include an independent appeal and review process for disputed peer review outcomes by a health insurance company.

Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies
Introduction:
Activities conducted by health insurance companies to evaluate the performance of physicians may or may not constitute "peer review" or "professional review activity" under Massachusetts or federal law, depending on whether or not such activities fall within the requisite statutory definitions. The MMS believes that all such activities, however, should follow a fair, evidence-based, ethical, and coherent process, and has therefore adopted the following Model Principles for Professional Review of Physicians within Health Insurance Companies as guidance for such activities as may be applicable to their setting.

The following recommendations are made based on the above considerations in order to enhance:

- Quality improvement
- Credibility in the process of medical professional/peer review of
- physicians
- Fairness and due process
- Patient access — by not inappropriately terminating, removing or sanctioning physicians
- System approaches to patient safety and quality of care

Model Principles for Medical Professional Review of Physicians within Health Insurance Companies

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event should include not only pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician on a confidential basis. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the "incident" and explore alternate courses of action, all on a confidential basis.
4. The process should be mindful of, and attuned to, prevention; and the outcome should include recommendations, if appropriate, for individual remediation.

5. Triggers that initiate a medical professional review within a health plan should be valid, transparent and available to all credentialed, participating provider or contracted physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process. Such cases should be referred to Physician Health Services, Inc., or another appropriate physician health or wellness program.
7. At a minimum, the standards set by the Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity for "professional review bodies" should be followed if a disciplinary process is engaged during medical professional review. These standards are the most elementary safeguards of due process for medical professional review activities.

Section 11112 Standards for professional review actions
"a. In general…professional review action must be taken–
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."

"Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):
(1) Notice of proposed action
The physician has been given notice stating –
(A) (i) that a professional review action has been proposed to be taken against a physician
(ii) reasons for the proposed action
(B) (i) that the physician has the right to request a hearing on the proposed action
(ii) any time limit (of not less than 30 days) within which to request such a hearing, and
(C) a summary of the rights in the hearing under paragraph (3).
(2) Notice of hearing–If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –
(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.
(3) Conduct of hearing and notice–If a hearing is requested on a timely basis under paragraph (1)(B) –
(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –
(i) before an arbitrator mutually acceptable to the physician and the health care entity,
(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
(C) in the hearing the physician involved has the right –
(i) to representation by an attorney or other person of the physician's choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right–
(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision."
In addition, the notice of hearing should contain a summary of the allegations and of the episodes of care under evaluation.

8. Summary termination of credentials or of participating provider contract or status (or, if applicable, suspension or restriction of clinical privileges) should only be used to prevent "imminent danger to the health of any individual." Such summary actions should be followed by adequate notice and hearing procedures prior to becoming final.
9. All parties involved in the medical professional review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the medical professional review process should be available to the subject physician to the fullest extent legally permissible.
10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic competitors of the subject physician or those for whom there may be bias or lack or objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician's specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. Participants on a medical professional review panel or peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the corrective action or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statutory protections.
11. Health plans should employ mechanisms to rotate service on their medical professional review panels or peer review committees among their credentialed, participating provider or contracted physicians.
12. Membership on the medical professional panel or peer review committee should be open to all credentialed, participating provider or contracted physicians in the health plan and not be restricted to one or more groups such as employed or salaried physicians only. The committee should include more than just medical directors, medical officers or other administrative officers of the health plan.
13. Only physicians are peers of the subject physician, and only physicians should be voting members of committees conducting medical professional review of physicians.
14. Whenever a medical professional review panel or peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the health plan while excluding direct economic competitors, or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution (e.g., medical specialty society) authorized to conduct peer review of physicians should be appointed in accordance with the health plan's bylaws if such actions fall within statutory medical professional/peer review protections.
15. Physicians serving on the medical professional review panel or peer review committee should receive information and, where available, training, in the elements and essentials of medical professional/peer review.
16. The health plan should ensure that the physicians serving on any medical professional review panel or peer review committee are provided with appropriate indemnification and insurance for medical professional/peer review acts taken in good faith. The health plan should also provide assistance to the panel or committee in abiding by the requirements of HCQIA to be eligible for federal immunity if applicable.
17. The medical professional review panel or peer review committee of a health plan should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination on matters of quality care or professional competency. When the matter before the medical professional review panel or peer review committee involves professional conduct, such as an allegation of disruptive behavior, the medical professional review panel or peer review committee should be guided by applicable professional ethical principles (e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards, practices and principles should be made available in a timely manner to the subject physician before any hearing on the matter.
18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.
19. Wherever feasible, structured assessment instruments and, if available, multiple reviewers should be used to increase reliability.
20. Where feasible, statistical analysis to compare with peers' performance should be used with appropriate case mix adjustment.
21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.

22. All the pertinent information obtained by the medical professional review panel or peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.
23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.
24. Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.
25. If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.
26. The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it should address what specific remediation, if any, is recommended for the physician (whenever feasible, in terms that permit measurement and validation of remediation, when completed).
27. A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the health plan, should be made available to the subject physician within statutory medical professional/peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.
28. In all instances of medical professional review activities conducted within health insurance companies, the applicable processes and procedures should be clearly stated, with specific detail, in health plan provider manuals or written policies, of uniform application, made available in advance to the subject physician. Such processes and procedures should contain the particular due process, hearing and appeals rights available to the subject physician, and, to the extent that medical professional review or peer review privilege, confidentiality and immunity legal protections are available to such medical professional review activities, such processes and procedures should conform to the requirements of federal and state law. In conformity with Principle No. 12, to avoid or at least mitigate conflicts of interest, or the perception thereof, the medical professional review panels or peer review committees of health insurance companies should include as members with full participation and voting rights physicians who are not employees or contractors (other than contracting as a participating provider) of the health insurer.
29. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. (MMS Council, 5/17/91; Reaffirmed, House of Delegates, May 7, 1999)
30. These Model Principles for Medical Professional Review of Physicians within Health Insurance Companies are intended to apply to all medical professional review activities conducted by health insurance companies of their credentialed, participating provider or contracted physicians, however designated: e.g., professional review, peer review, credentialing appeals, corrective actions or otherwise.

(HP)
(MMS House of Delegates, 5/08/09)

The Massachusetts Medical Society amends its existing Model Principles for Incident-Based Peer Review for Health Care Facilities to include an independent appeal and review process for disputed peer review outcomes by a hospital and to update the principles to account for changes in regulations and standards developed since the principles were created in 2003 as to read as follows:

Massachusetts Medical Society Policy
Model Principles for Medical Peer Review of Physicians for Health Care Facilities

The following recommendations are made based on the above considerations in order to enhance:
• Quality improvement

• Credibility in the process of medical peer review of physicians for health care facilities
• Fairness and due process
• Patient access — by not inappropriately removing or sanctioning physicians
• System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care facility must not only include pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the "incident" and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.
7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.

Section 1112 Standards for professional review actions

"a. In general…professional review action must be taken–

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."

"Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating –

(A) (i) that a professional review action has been proposed to be taken against a physician

(ii) reasons for the proposed action

(B) (i) that the physician has the right to request a hearing on the proposed action

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing–If a hearing is requested on a timely basis under paragraph (1) (B), the physician involved must be given notice stating –

(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice–If a hearing is requested on a timely basis under paragraph (1)(B) –

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –

(i) to representation by an attorney or other person of the physician's choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right
(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision."
In addition, the notice of hearing should contain a summary of the allegations and the episodes of care under evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to prevent "imminent danger to the health of any individual." Such summary actions must be followed by adequate notice and hearing procedures prior to becoming final.
9. All parties involved in the peer review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the peer review process shall be available to the subject physician to the fullest extent legally permissible.
10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician and should include a fair representation of specialists/subspecialists from the subject physician's specialty/subspecialty whenever feasible. Participants on a peer review committee should disclose relevant conflicts of interest and, when appropriate, recuse themselves from the peer review or disciplinary proceeding. Additionally, the subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.
11. Physicians should rotate service on the peer review committee (round robin).
12. Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.
13. Only physicians should be voting members of committees conducting medical peer review of physicians.
14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.
15. Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.
16. The hospital or the organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the requirements of HCQIA to be eligible for federal immunity.
17. The peer review committee of a health care facility should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination. When the matter before the peer review committee involves professional conduct such as an allegation of disruptive behavior, the peer review committee should be guided by applicable professional ethical principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards and practices must be made available in a timely manner to the subject physician before any hearing on the matter.
18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.
19. Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability.
20. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustment.

21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.
22. All the pertinent information obtained by the peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.
23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.
24. Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.
25. If the conclusion reached is that improvement is necessary, any action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system.
26. The findings, recommendations and actions of the peer review committee of a health care facility should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it must address what specific remediation, if any, is recommended for the physician and what, if any, for the system (whenever feasible, in terms that permit measurement and validation of remediation, when completed).
27. A process should be available to appeal any disciplinary finding of a health care facility following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the medical staff or the hospital, should be made available to the subject physician within statutory peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.

(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)

28. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. (MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)

MMS House of Delegates, 11/08/03
**Health Care Facilities Principles Amended and Reaffirmed, MMS House of Delegates, 5/08/09*
Amended and Reaffirmed, MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 4/28/18

(HP)

The Massachusetts Medical Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. *(HP)*

MMS Council, 5/17/91
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Professional Responsibility

The Massachusetts Medical Society adopts the Declaration of Professional Responsibility: Medicine's Social Contract with Humanity, which reads as follows:

DECLARATION OF PROFESSIONAL RESPONSIBILITY:
MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while

promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly, and at times heroically. Today, our profession must affirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration
We, the members of the world community of physicians, solemnly commit ourselves to:

I. Respect for human life and the dignity of every individual.

II. Refrain from supporting or committing crimes against humanity and condemn all such acts.

III. Treat the sick and injured with competence and compassion and without prejudice.

IV. Apply our knowledge and skills when needed, though doing so may put us at risk.

V. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

VI. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

VII. Educate the public and polity about present and future threats to the health of humanity.

VIII. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

IX. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.
(HP)

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Supervision of Non-physicians
The MMS will work with relevant entities to ensure physicians on staff receive written notification when their license is being used to document "supervision" of non-physician practitioners. The physician's supervisory responsibilities should be defined and agreed upon between the physician and the entity. *(D)*

The MMS will advocate for advanced notice and disclosure to physicians before they are hired or as soon as practicably known by provider organizations and institutions that anticipate physician supervision of non-physician practitioners as a condition for physician employment. *(D)*

The MMS will advocate that organizations, institutions, and medical staff that have physicians who participate in supervisory duties for non-physician practitioners have processes and procedures in place that have been developed with appropriate clinical physician input. These processes and procedures should be adequate to assure patient safety and appropriate clinical care and are fully disclosed to physicians. *(D)*

The MMS will advocate that physicians be able to report professional concerns about care provided by non-physician practitioners to the appropriate leadership within the institution or organization with protections so as not to be retaliated against by the physician's employer in any way. *(D)*

MMS House of Delegates, 12/10/22

The Term "Physician"
The MMS affirms that the term "physician" be applied and limited to those people who have attained a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), or a recognized equivalent physician degree. *(HP)*

The MMS will utilize the term "physician" and discontinue use of the term "provider" when referring to an MD or DO in all communications, including but not limited to conferences, media, publications, and public relations messaging. *(D)*

The MMS will advocate that future references to physicians by state government, insurance companies and other health care entities in contracts, advertising, agreements, published descriptions, and other communications utilize the term "physician" and discontinue use of the term "provider." *(D)*

The MMS will urge physicians to insist on being identified as a physician, to sign only those professional or medical documents identifying them as physicians, and not to let the term physician be used by any other person involved in health care. *(D)*

MMS House of Delegates, 12/7/19
(Item 5 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/10/22)

Workforce
The Massachusetts Medical Society (MMS) will continue to monitor physician workforce issues through primary and secondary research, including working with health care leaders, as appropriate. *(D)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Items 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society (MMS) will continue to monitor physician workforce issues through primary and secondary research. *(D)*

The MMS will develop advocacy efforts to increase public, legislative, and health plan awareness of the impending shortage in physician staffing and its impact on access to care. *(D)*

The MMS will focus further analysis on evaluating the effects of non-patient care activity, such as research, teaching, and biotechnology, on the practicing physician workforce. *(D)*

The MMS will look for collaborative opportunities with physician specialty societies, health care delivery systems, and other appropriate health care organizations to study and advance initiatives related to the physician workforce and patient access to care. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

MMS will advocate, as soon as is fiscally prudent, for fully funding efforts aimed at encouraging the entry and retention of more primary care physicians in the Commonwealth, such as programs to address the high cost of living in Massachusetts and various other incentives for primary care physicians. *(D)*

MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

PREAUTHORIZATIONS

Office Practice Expenses
The MMS will sponsor legislation requiring insurance companies doing business in Massachusetts to reimburse reasonable physician office practice expenses related to physician processing of prior authorizations for medications and procedures which require a medical decision/review by a physician or other licensed health professionals under his/her supervision and/or liability coverage. *(D)*

MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Preauthorizations/Decision-Making

The MMS will oppose proposed legislation introducing unnecessary paperwork into the patient-physician relationship especially as it can interfere with timely treatment for acute illnesses. *(D)*

MMS House of Delegates, 5/8/21
(Item 1 of Original Auto-Sunset: Time-Limited Directive Completed MMS House of Delegates, 5/21/22)

The Massachusetts Medical Society will expand and initiate advocacy efforts in the Commonwealth of Massachusetts to require pharmacies, EHR vendors, pharmacy benefit managers, payers, and other entities responsible for processing and providing patients with prescriptions that require prior authorization to provide accurate, complete, and actionable information to prescribing physicians or their agents. Such information must enable Prior Authorization Request submissions to be more transparent and efficient. *(D)*

MMS House of the Delegates, 12/1/18

The Massachusetts Medical Society will advocate for the elimination by all Massachusetts health insurers of all prior authorization requirements or other special billing/administrative maneuvers that inhibit patient access to buprenorphine/naloxone. *(D)*

MMS House of Delegates, 12/1/18

The MMS will advocate that third-party payers and pharmacy benefits managers must provide access to the medical director and/or the author of the prior authorization policy to the provider, to discuss the disputed care and the care management within 2 business days of the provider requesting such access. The request for such access to the medical director may be made by phone or in writing, whichever is most convenient for the provider who is administering care of said patient. *(D)*

MMS House of Delegates, 4/28/18

The MMS will advocate for the enforcement of current legislation stating that all prior authorization requests made to insurers subject to state insurance law will be deemed approved if the third-party payer does not respond within two (2) business days. *(D)*

The MMS will advocate for legislation that at the time of a medication prior authorization denial, the pharmacy benefits manager must provide the prescriber with a list of appropriate preferred alternative medications. *(D)*

The MMS will advocate for legislation that in the event of a rejection of a prior authorization request made to insurers subject to state insurance law, the insurance company will have two (2) business days to respond to an appropriately filed appeal and that the medical professional reviewing the appeal must have the authority to overturn the initial denial. *(D)*

The MMS will advocate for and pursue with our legislators a mandate requiring that insurers who choose to contract in the state must similarly comply with an electronic pre-authorization process, making it necessary for the pre-authorization process to be readily available to all physicians in the Commonwealth, to work seamlessly on EMR/media, for medications, diagnostic imaging, and medical services in the same manner that paper submission is accepted. *(D)*

MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The process of electronic pre-authorization should be one that is immediate and accessible in real-time, with approval or denial at the point of contact. *(HP)*

It should be the responsibility of the insurer to provide transparency and full disclosure of formulary medications, acceptable alternatives, covered products and services, co-pays, and restrictions in electronic format to facilitate a less costly, more patient-centered, more expedient, and more satisfying method of pre-authorization. *(HP)*

The MMS will review and revise as necessary its Principles for the Use of Prior Authorization Programs with specific attention paid to the electronic pre-authorization process. *(D)*

The MMS will advocate for requiring insurers to make meaningful payments for time spent by physicians and staff for each communication needed to obtain prior authorizations for approval for services. *(D)*

Electronic pre-authorization should not be the sole method for pre-authorization submission. Alternate methods such as fax, telephone, and paper should be allowed. *(HP)*

MMS House of Delegates, 12/7/13
Reaffirmed MMS House of Delegates, 12/5/20

The MMS will:
… attempt to identify legislative, regulatory, and third-party requirements and strategies that are most burdensome *(D)*
MMS House of Delegates, 12/2/12
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/4/19

The MMS will foster, via regulatory or legislative avenues, elimination of prior authorization requirements for medication approved by the FDA for the specific indication requested and are comparatively cost-effective to alternatives. *(D)*

The MMS will encourage and facilitate provider reporting of undue delays in accessing the preauthorization process, obtuse denial explanations and undue delays in ultimately approved requests to the Division of Insurance (DOI); and, that the MMS request the DOI to require the health plans to submit their pre-authorization performance data to the DOI them in a common format for public disclosure and share these results with MMS, payers, and other appropriate entities for a collaborative discussion. when known, the clinical consequences of each delay by way of a simple reporting form by whatever medium stored in a database maintained by the MMS and, in turn, periodically reported to appropriate regulatory authorities and MMS membership. *(D)*

MMS House of Delegates, 5/19/12
Items 1-3 of Original: Reaffirmed MMS House of Delegates, 5/4/19
(Item 2 of Original: Sunset)

The MMS opposes the use of preauthorization where the medication or procedure prescribed is a common and indicated one or commonly used medication for the indication as supported by peer-reviewed medical publications. *(HP)*

Any reviewer at any level of the preauthorization process be fully identified by full name, title, and location; educational level; and contact information of supervisor. *(HP)*

Third parties should make available to the Massachusetts Medical Society meaningful, aggregate statistics in usable form in a timely fashion (e.g., broken down by specialty, medication, diagnostic test, or procedure; indication offered and reason for denial and outcomes analysis) of percentages of acceptance or denial as well as other relevant trending information. Individual medical group data should be made available upon request by each group. *(D)*
MMS House of Delegates, 5/14/11
Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) opposes pre-certification programs of third-party payers that interfere with the physician-patient relationship, delay medically necessary care, or impose an undue administrative burden on physicians. *(HP)*

The MMS will work with third-party payers to develop meaningful hassle-free utilization review programs that are educational in design and enhance quality of patient care. *(D)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

The MMS takes the position that decision-making regarding preauthorization of payment for medically necessary services and treatment is the defacto practice of medicine, and those involved in those reviews should be held liable for bad outcomes and in malpractice actions stemming from delay and/or denial of care. *(HP)*

MMS House of Delegates, 12/4/10
Reaffirmed MMS House of Delegates, 4/29/17

Principles for the Use of Prior Authorization Programs
That the Massachusetts Medical Society adopt the following adapted from the AMA Prior Authorization and Utilization Management Reform Principles
(02/07/22).

Preamble: Patients and physicians often find that prior authorization interferes with their ability to access care. In an ideal visit, physicians and patients will come to a shared decision on a treatment plan. However, the patients oft times go home and find their treatment is not available to them. Prior authorization can create distrust for the patient and adds significant burden to the physician and their practice. Prior authorization can delay care and can be a patient safety risk. For these and other reasons, the following 19 principles have been adapted from the AMA and are listed here.

Principle #1: Any utilization management program applied to a service, device or drug should be based on criteria to the maximum extent feasible, scientifically derived and evidenced based, and developed with input of participating physicians based on accurate and up-to-date clinical criteria and not solely cost alone. The referenced clinical information should be readily available to the prescribing/ordering physician and the public.

Principle #2: Utilization review criteria shall be up to date, applied consistently by a carrier, made easily accessible to all on website, through link, or individually to physician or subscriber when licensed propriety. No new requirement or restriction shall be implemented without clear notice to the website.

Principle #3: Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.

Utilization review entities should offer an appeals system for their utilization management programs that allows a prescribing/ordering physician direct access, such as a toll-free number, answered in a timely way to a physician licensed in the appropriate specialty related to such health services for discussion of medical necessity issues.

Principle #4: Utilization review entities should offer a minimum of a 60-day grace period for any step therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements (e.g., prior authorization, step therapy overrides, formulary exceptions, etc.) are addressed.

Principle #5: A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.

Principle #6: A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment. The prior authorization should extend for the length of the course of treatment or at least one year.

Principle #7: No utilization review entity should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy.

Principle #8: Utilization review entities should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by physicians and patients, including prospective patients engaged in the enrollment process. Additionally, utilization review entities should clearly communicate to prescribing/ordering physicians what supporting documentation is needed to complete every prior authorization and step therapy override request.

Principle #9: Utilization review entities should provide, and vendors should display, accurate, patient specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record (EHR) systems for purposes that include e-prescribing.

Principle #10: Utilization review entities should make statistics regarding prior authorization approval and denial rates available to physician organizations and health systems.

Principle #11: Utilization review entities should provide detailed explanations to patients and physicians of prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination, provide the plan's covered alternative treatment, and detail the patient and physician's appeal rights.

Principle #12: A utilization review entity requiring physicians to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. However, electronic pre-authorization should not be the sole method for pre-authorization submission. Alternate methods such as fax, telephone, and paper should be allowed.

Principle #13: A utilization review entity should not revoke, limit, condition, or restrict coverage for authorized care.

Principle #14: If a utilization review entity requires prior authorization for non-urgent care, the entity should make a determination and notify the physician within two business days of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information.

Principle #15: Should a physician determine the need for an expedited appeal, a decision on such an appeal should be communicated by the utilization review entity to the physician and patient within 24 hours. Physicians and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider (a) licensed in the appropriate specialty related to such health services-and (b) not involved in the initial adverse determination.

Principle #16: Prior authorization should never be required for emergency care, regardless of where the care is provided.

Principle #17: Utilization review entities should standardize criteria across the industry to promote uniformity and reduce administrative burdens.

Principle #18: Under certain circumstances health plans should be able to offer physicians/practices prior authorization "gold-card" status to those with a history of meeting appropriate use criteria, clinical decision support systems, or clinical pathways.

Principle #19: A physician that contracts with a health plan to participate in a financial risk-sharing payment plan should be offered the option to be exempt from prior authorization and step-therapy requirements for services covered under the plan's benefits.

Principle #20: A physician that contracts with a health plan shall have access to the identity of the agent/agency that developed the prior authorization criteria, and contact information as to how and where to suggest feedback on said criteria to a responsible individual.
(HP)

MMS House of Delegates, 12/3/05
Amended and Reaffirmed MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 12/6/14
Amended and Reaffirmed MMS House of Delegates, 5/21/22

PRESCRIPTION AND NON-PRESCRIPTION DRUGS

Biosimilar Medications
The MMS will advocate via regulatory or legislative avenues that so-called bioequivalent (i.e., generic) substitutions for narrow therapeutic index agents (or those prescribed for treatment of conditions where potential harm of variable bioavailability, prescription to prescription, of said substitution is substantial) not be mandated and/or be limited to no more frequently than once a year, especially for economic reasons alone. This should apply not only to substitutions for branded agents, but also to other generic so-called bioequivalent agents of the same molecular structure. *(D)*

The MMS will advocate via regulatory or legislative avenues that biosimilar medications not be substituted without the express endorsement of the prescribing physician. *(D)*

MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

The MMS endorses the following AMA policies:
D-125.989 Substitution of Biosimilar Medicines and Related Medical Products.

Our AMA will: (1) monitor legislative and regulatory proposals to establish a pathway to approve follow-on biological products and analyze these proposals to ensure that physicians retain the authority to select the specific products their patients will receive; and (2) work with the U.S. Food and Drug Administration and other scientific and clinical organizations to ensure that any legislation that establishes an approval pathway for follow-on biological products prohibits the automatic substitution of biosimilar medicines without the consent of the patient's treating physician. (Res. 918, I-08)
(HP)
H-125.980 Follow-on Biologic Medications.

AMA policy is that pharmaceutical companies should be allowed to make follow-on biologic medications available to physicians and their patients in a reasonable period of time with a reasonably predictable pathway to bring them to market, and our AMA will advocate for enactment of federal law that would establish a pathway for follow-on biologic medications to be allowed on the market, with two guiding principles: 1) a reasonable time frame for US Food and Drug Administration exclusivity and patent expiration with a straightforward regulatory process for follow-on biologic competitors to be brought to market, and 2) the protection of patient safety in both the original branded products and all follow-on products that are brought to market. (Res. 220, A-09)
(HP)

The MMS and AMA will work with the FDA and any other relevant regulatory bodies that are responsible for assessing variance in bioequivalency and bioavailability of generic products and branded products so that the MMS and AMA are able to provide policy recommendations. *(D)*

MMS House of Delegates, 12/5/10
Reaffirmed MMS House of Delegates, 4/29/17

Cannabis/Medical Use of Cannabis
That the MMS opposes the public advertising, marketing, and promotion of cannabis in the state of Massachusetts using billboards, print and social media advertising, sponsorship, branding, and placement/density of retail locations, and other forms of public advertising. *(HP)*

That the MMS advocate for the use of current state and federal guidelines and regulations for tobacco as the standard for marketing, advertising, and product limitations for cannabis legislation. *(D)*

That the MMS urge the Massachusetts Cannabis Control Commission and/or the Massachusetts legislature to require all cannabis products sold in the state limit the concentration of THC in any preparation to no more than 10% and limit each dose delivered to a typical user to no more than 5 mg. *(D)*

That the MMS urge the Massachusetts Cannabis Control Commission and/or the Massachusetts legislature to prohibit the sale of products such as flavored and/or sweetened THC products appealing to individuals younger than 25 years of age. This includes restrictions on packaging and branding attractive to these individuals. *(D)*

That the MMS urge the Massachusetts Cannabis Control Commission and/or the Massachusetts legislature to require prominent labeling of all packaging and advertising of cannabis products, with current, evidence-based warnings, with attention to vulnerable populations and those with low health literacy.
(D)

That the MMS urges stakeholders to dedicate adequate resources, including
but not limited to those generated by cannabis excise taxes and addiction-related settlement funds, to statewide prevention and education efforts that include the following:
1) Public warnings for adults and youth about risks of cannabis, especially use of cannabis with greater than 10% THC content, including Emergency Department crowding and overburdening, cannabis addiction, psychosis, suicide attempt or self-injurious behavior, mental illness, cannabinoid hyperemesis syndrome, child poisonings, and impaired driving
2) Cannabis use prevention and education at schools, especially in underserved communities
3) Treatment of cannabis use disorder

MMS House of Delegates, 5/21/22

The Massachusetts Medical Society adopts the following policies on cannabis and medical use of cannabis:

The Massachusetts Medical Society, in its consideration of cannabis for medical and recreational purposes, is guided by principles which aim to do the following:

- Promote the patient-physician relationship
- Increase the body of scientific evidence about cannabis use
- Promote the most effective treatment options
- Encourage harm reduction
- Protect public health and vulnerable individuals
- Achieve health equity and promote social justice
- Reduce stigma

(HP)

The MMS recognizes that there is a growing body of evidence regarding the benefits and risks of cannabis. *(HP)*

The MMS will base its advocacy activities on the strength of the available scientific evidence. *(HP)*

The MMS will advocate at the state and federal levels for policies and funding to advance research into cannabis. *(HP)*

That MMS will advocate for efforts at the state level that protect public health, with particular attention to protecting vulnerable populations, preventing impaired driving, and preventing and treating cannabis misuse and cannabis use disorder. *(HP)*

That MMS encourages open communication between physicians and patients with regard to cannabis use. *(HP)*

The MMS encourages physicians to become educated about emerging cannabis research and to be aware of guidance from pertinent medical societies and public health agencies. *(HP)*

MMS House of Delegates, 12/5/20
(Item 8 of Original Auto-Sunset: Time-Limited Directive Completed, MMS House of Delegates, 12/4/21)

Compounding Pharmacies

The MMS must act with regards to legislative and regulatory oversight of compounding pharmacies, and in doing so will:

1. Support that traditional compounding pharmacies must be subject to the Massachusetts Board of Registration in Pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications.

2. Recognize the accreditation program of the Pharmacy Compounding Accreditation Board (PCAB™) and the PCAB™ Seal of Accreditation as a means to identify compounding pharmacies that adhere to quality and practice standards, including those set forth in the USP-NF, for the preparation of individualized medications for specific patients.

3. Encourage the MA State Board of Pharmacy to require compounding pharmacies to obtain the PCAB™ Seal of Accreditation or, alternatively, to satisfy comparable standards that have been promulgated by the state in its laws and regulations governing pharmacy practice.

4. Support the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce, be recognized as compounding manufacturers subject to appropriate state and federal oversight and regulation.

5. Support the view that allowances should be made for the conduct of compounding practices that can realistically supply compounded products needed to manage urgent and emergency care scenarios in a safe manner.

In the absence of new federal legislation affecting the oversight of compounding pharmacies, continue to encourage the MA Board of Registration in Pharmacy to work with the appropriate national governmental agencies to identify and take

appropriate enforcement action against any entities that are illegally manufacturing medications under the guise of pharmacy compounding.
(D)

MMS House of Delegates, 12/7/13
Reaffirmed MMS House of Delegates, 12/5/20

Decriminalizing Possession of Opioids and other Illicit Substances for Personal Use
The MMS recognizes the importance of decriminalizing opioids and other illicit substances, making possession of these drugs a civil offense rather than a criminal offense and enhancing treatment over incarceration which significantly minimizes risk of harm to those who suffer from substance use disorders. *(HP)*

The MMS supports decriminalization of personal drug use and possession for personal drug use, enhancing treatment over incarceration, which significantly minimizes risk of harm to those who suffer from substance use disorder. This should not be misconstrued as an endorsement of recreational drug use. *(HP)*

The MMS will advocate for decriminalization of personal drug use and possession for personal drug use to the state and federal legislatures and to the AMA. This should not be misconstrued as an endorsement of recreational drug use. (*D)*

The MMS will continue to research the evolving evidence-based literature regarding decriminalizing substances and share that information with members through member newsletter articles and planned educational sessions. *(D)*

MMS House of Delegates, 12/4/21

Direct-to-Consumer Advertising
The MMS will advocate that pharmaceutical companies will have no ordinary and necessary business tax deductions for any direct-to-consumer advertising expenses for prescription drugs. *(D)*

(Approved MMS Board of Trustees, 2/8/17)
Accepted MMS House of Delegates, 4/29/17

The MMS will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs. *(D)*

MMS House of Delegates, 12/3/16
(Item 2 of Original: Auto-Sunset, Time-Specific Directive Completed, MMS House of Delegates, 12/2/17)
(Reaffirmed for 1 Year Pending Review at A-24)

The MMS supports public reporting of all direct-to-consumer advertising expenses by pharmaceutical companies based on uniform accounting procedures, and opposes such costs being passed on to the public, thereby eliminating increased pricing to the consumer. *(HP)*

MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23
(Item 2 of Original: Sunset)

The MMS will advocate for Massachusetts and federal legislation to ban direct-to-consumer drug ads in Massachusetts and in the United States. *(D)*

MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Drug Formularies
The MMS supports the goal of creating a single, comprehensive, online, EMR-accessible, cross-referenced formulary list arranged by drug category that will allow all stakeholders, including the pharmacy, to clearly show which medication of the same class is approved by each individual patient's insurance plan. *(HP)*

MMS House of Delegates, 5/8/21

The MMS will advocate that all payors make all their formularies available online to all beneficiaries, and their physicians and pharmacists, in a format that is searchable, updated monthly, and includes categorization by indication. *(D)*

The MMS will advocate for legislation to require that all payors post all their formularies online to all beneficiaries, and their physicians and pharmacists, in a format that is searchable, updated monthly, and includes categorization by indication. *(D)*

MMS House of Delegates, 12/7/19

Principles on Prescription Coverage

A. Fundamental Principle

1. Fundamental Principle

The Massachusetts Medical Society (MMS) affirms its commitment to support the access of all patients to medically necessary and appropriate prescription medications.

B. Prescribing

1. Formularies

The MMS supports the continuous development of simplified rational formularies of preferred drugs, and should work with providers and insurers, including Medicare and Medicaid, to achieve this goal. Such formularies should be readily available in print and through electronic media. Physicians should have significant input into all formulary development.

2. Legislative/Regulatory

The MMS shall support legislative and regulatory positions, which support the rights of patients and physicians to choose the appropriate medication for the patient on a clinical basis.

3. Safe and Efficacious Drug Therapies

The MMS believes that the most safe and efficacious drug therapies should be identified by the application of evidence-based medicine.

C. Education

1. Physician Education

Physicians should be continually educated in clinically appropriate, cost-effective prescribing, and should be encouraged to incorporate the information into their prescribing practices.

2. Patient Responsibility

The MMS supports ongoing efforts to provide patients with objective information on medications, their appropriate use, and their cost.

3. Pharmaceutical Industry Input/Insurance Industry Input

Physicians should avoid undue influence from pharmaceutical companies, insurance companies, and health plans that could influence prescription writing. The MMS supports objective education of physicians by

D. Coverage/Benefits

1. Basic Pharmacy Benefit Coverage

The MMS supports additional allocation of resources for the provision of pharmacy coverage as a basic Medicare benefit.

2. Affordability

The MMS supports efforts to decrease the costs of medications for our patients.

3. Patient Contribution

Cost contributions from patients may be appropriate as long as they do not deter patients' access to prescription medications.

(HP)

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Physicians should be encouraged to use resources appropriately and practice efficiently, including bioequivalent substitution of medications when there is no apparent risk to the patient. *(HP)*

The Committee on Legislation shall support legislative and regulatory positions which support the rights of patients and physicians to choose the appropriate medication for the patient on a clinical basis.*(HP)*

The Massachusetts Medical Society urges physicians to learn more about the practices of PBMs and become alert to industry-based initiatives in disease management. *(HP)*

The MMS shall continue its work to increase the ready availability to practicing physicians of information about the content of specific formularies. *(D)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Items 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/14/19

The MMS endorses the AMA policy on National Drug Shortages, as revised and updated in 2022, which reads as follows:

1. Our AMA considers drug shortages to be an urgent public health crisis, and recent shortages have had a dramatic and negative impact on the delivery and safety of appropriate health care to patients.

2. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that are in short supply, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

3. Our AMA supports authorizing the Secretary of the U.S. Department of Health and Human Services (DHHS) to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

4. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

5. The Council on Science and Public Health shall continue to evaluate the drug shortage issue, including the impact of group purchasing organizations and pharmacy benefit managers on drug shortages, and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

6. Our AMA urges continued analysis of the root causes of drug shortages that includes consideration of federal actions, evaluation of manufacturer, Group Purchasing Organization (GPO), pharmacy benefit managers, and distributor practices, contracting practices by market participants on competition, access to drugs, pricing, and analysis of economic drivers, and supports efforts by the Federal Trade Commission to oversee and regulate such forces.

7. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market or caused to stop production due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

8. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

9. Our AMA will collaborate with medical specialty society partners and other stakeholders in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.

10. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages.

11. Our AMA urges the FDA to require manufacturers to provide greater transparency regarding the pharmaceutical product supply chain, including production locations of drugs, and provide more detailed information regarding the causes and anticipated duration of drug shortages.

12. Our AMA supports the collection and standardization of pharmaceutical supply chain data in order to determine the data indicators to identify potential supply chain issues, such as drug shortages.

13. Our AMA encourages global implementation of guidelines related to pharmaceutical product supply chains, quality systems, and management of product lifecycles, as well as expansion of global reporting requirements for indicators of drug shortages.

14. Our AMA urges drug manufacturers to accelerate the adoption of advanced manufacturing technologies such as continuous pharmaceutical manufacturing.

15. Our AMA supports the concept of creating a rating system to provide information about the quality management maturity, resiliency and redundancy, and shortage mitigation plans, of pharmaceutical manufacturing facilities to increase visibility and transparency and provide incentive to manufacturers. Additionally, our AMA encourages GPOs and purchasers to contractually require manufacturers to disclose their quality rating, when available, on product labeling.

16. Our AMA encourages electronic health records (EHR) vendors to make changes to their systems to ease the burden of making drug product changes.

17. Our AMA urges the FDA to evaluate and provide current information regarding the quality of outsourcer compounding facilities.

18. Our AMA urges DHHS and the U.S. Department of Homeland Security (DHS) to examine and consider drug shortages as a national security initiative and include vital drug production sites in the critical infrastructure plan.

19. Our AMA urges the Drug Enforcement Administration and other federal agencies to regularly communicate and consult with the FDA regarding regulatory actions which may impact the manufacturing, sourcing, and distribution of drugs and their ingredients.

(Approved MMS Board of Trustees,3/1/23)
Accepted MMS House of Delegates, 5/13/23

Education Regarding Industry Marketing and Advertising
The MMS will encourage all Massachusetts medical schools and residency programs to educate their students and resident physicians on the possible effects of pharmaceutical, device, and equipment marketing and advertising on care of patients, on various ethical policies on gifts to physicians from industry, and on alternative unbiased sources of information about pharmaceutical products, device, and equipment. *(HP)*

MMS House of Delegates, 5/31/02
Amended and Reaffirmed MMS House of Delegates, 5/8/09
(Items 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The MMS supports the concepts that (a) physicians maintain a heightened awareness at all times of the implied and perceived obligations regarding all interactions with the pharmaceutical and medical device industry, and that (b) perception of physicians' behavior should be considered with each contact with industry representatives. *(HP)*

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/04
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 4/28/18

Generic Drugs
Our MMS will advocate for the FDA to waive or reduce entry fees and expedite approval processes for new manufacturers to enter the market for a critical generic medication when the FDA determines that there have been inappropriate significant price increases for that medication. *(D)*

The MMS will advocate for the FDA to allow the importation of a generic medication from selected manufacturers if production of that medication is a monopoly here in the United States. *(D)*

MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society will work with the AMA, FDA and any other relevant regulatory bodies to investigate the allowable variance in bioequivalency and bioavailability of generic products and branded products. *(D)*

MMS House of Delegates, 12/5/09
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Limits on Medications and Testing or Treatment Supplies
The MMS will advocate to prevent health care insurers from basing their coverage of a prescription on how many days' supply is ordered or dispensed. *(D)*

MMS House of Delegates, 12/7/19

The MMS will advocate with third-party payers and federal and state entities to ensure that, if a payer uses quantity limits for prescription drugs or testing and treatment supplies, an exceptions process is in place to make certain that patients can access higher or lower quantities of prescription drugs, testing, or treatment supplies based on medical necessity, and that any such process should minimize the burden upon patients, physicians and their staff. *(D)*

The MMS supports the protection of the patient-physician relationship from interference by insurers' various utilization control mechanisms, including unreasonable medication limits and testing or treatment supply quantity limits. *(HP)*

MMS House of Delegates, 12/1/12
Item 1: Reaffirmed MMS House of Delegates, 5/4/19
Item 2 of Original: Amended and Reaffirmed MMS House of Delegates, 12/7/19

Medically-Supervised Safe Injection Facility Pilot
The MMS will advocate for a pilot supervised injection facility (SIF) program in Massachusetts under the direction and oversight of a state-led task force convened by a state authority, such as the MA Department of Public Health, to discuss the legal considerations and paths forward, and that the task force:

- Advocate for an exemption from federal drug laws for the pilot SIF program as well as pursue state legislation legalizing the pilot SIF program, and consider partnering with other states or entities in seeking such a waiver of the applicable federal laws.
- Include an advisory board of experts, which includes experts from the Vancouver SIF as well as state and federal government officials if possible, under the jurisdiction of the task force, to design the evaluation protocol (including careful design of informed consent protocols regarding research) for the pilot.
- Consider building on a program such as a supportive place for observation and treatment (SPOT), given its expertise providing comprehensive, high-quality, harm-reduction services to populations that would be served by SIFs, and its reputation with government officials and other stakeholders in Boston.
- Consider harm-reduction strategies (counseling, referral, and placement on demand for all types of drug treatment) as a component of the pilot beyond SIFs to ensure comprehensive health care is available to marginalized persons who inject drugs.

(D)

MMS House of Delegates, 4/29/17

Medication Withhold/Delays
The Massachusetts Medical Society (MMS) opposes third-party policies that interrupt patients' treatment regimens based on cost savings. *(HP)*

The MMS will work with appropriate regulatory bodies to ensure that neither pharmacies nor other insurer-pharmacy arrangements withhold or delay the filling and mailing of legitimate prescriptions to patients, while they attempt to obtain generic- or alternative-medication prescription changes. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Needle Exchange/Disposal
The MMS will advocate to the Massachusetts state legislature and/or relevant state agencies to increase public access to needle/syringe disposal and destruction devices with theft-proof and tamper-proof properties. *(D)*

The MMS will encourage Massachusetts communities to establish and expand needle exchange programs. *(D)*
MMS House of Delegates, 4/29/17

Off-Label Uses
The MMS strongly supports adding to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. *(HP)*

MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The MMS confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA-approved drug product or medical device for an off-label indication when such use is based upon scientific evidence or expert medical opinion. When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should be required to cover appropriate "off-label" uses of drugs on their formulary. *(HP)*

The MMS strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. *(HP)*

MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS strongly supports the dissemination of generally available information from manufacturers about off-label uses by physicians. Such information should be independently derived, peer reviewed, based on scientific evidence, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. *(HP)*

The MMS strongly supports the continued authorization, implementation, and coordination of biological license applications and new drug applications to include pediatric safety and effectiveness data. *(HP)*
MMS House of Delegates, 12/5/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Opioids/Nasal Naloxone *(Please Also See Policies Under Preauthorizations or Substance Use and Misuse)*
The MMS will research the medical literature on effective models of care to expand access to methadone for the treatment of opioid use disorder. Examples of these models could include providing interim methadone treatment in opioid treatment programs, integrated office-based prescribing involving pharmacists to dispense and observe dosing; and prescribing and dispensing in emergency departments, hospitals, detoxification programs, skilled nursing facilities, home care settings, and other controlled environments (e.g., jails and prisons) *(D)*

The MMS will use research on effective models of care to identify opportunities for advocacy to expand patients' access to methadone treatment and report back at I-21. *(D)*

MMS House of Delegates, 12/5/20

The MMS will educate physicians about current law allowing for the prescription and dispensing of naloxone and encourage appropriate prescription for patients at risk for opioid overdose. *(D)*

MMS House of Delegates, 12/1/12
Amended and Reaffirmed MMS House of Delegates, 12/7/19

The MMS supports the use of naloxone by medical first responders and trained non-medical personnel for the life-saving reversal of opioid overdose. *(HP)*

The MMS will advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose, and the use of naloxone. *(D)*

MMS House of Delegates, 5/19/12
Amended and Reaffirmed MMS House of Delegates, 12/7/19

The Massachusetts Medical Society will sponsor an educational session that will explore decriminalizing the use of illegal drugs and their possession in amounts consistent with personal use only and consider the impact that this approach could have on the Commonwealth of Massachusetts. Health care providers, legislators, health care administrators, and law enforcement officials should be among those invited to take part in the session. *(D)*

MMS House of Delegates, 5/2/19

The MMS states that current federal and state regulations of methadone for the treatment of opioid use disorder are overly restrictive and limit the clinically indicated use of methadone to treat opioid use disorder in the midst of the opioid crisis. *(HP)*

The MMS will advocate for amendment of federal and state laws to reduce current restrictions on the use of methadone for the treatment of opioid use disorder; while balancing the urgent need for expanded access with considerations for safe practices. *(D)*

MMS House of Delegates, 12/7/19

The MMS supports the elimination of the buprenorphine waiver requirement and related restrictions, including the cap on the number of patients that physicians are eligible to treat with buprenorphine. *(HP)*

MMS House of Delegates, 12/7/19

The MMS supports all national efforts and local endeavors to reduce the cost of naloxone auto-injectors, including generic naloxone into appropriate auto-injectors. *(HP)*

MMS House of Delegates, 12/2/17

The Massachusetts Medical Society will advocate to expand coverage for evidence-based non-opioid pharmacologic and non-pharmacologic pain management options. *(D)*

The Massachusetts Medical Society will advocate for the elimination of prior authorization and other utilization-management obstacles to evidence-based non-opioid pharmacologic and non-pharmacologic pain management options. *(D)*

MMS House of Delegates, 12/1/18

The MMS will work with relevant organizations to promote awareness of the naloxone standing order to physicians, pharmacists, and patients. *(D)*

The MMS will strongly advocate for affordable access to naloxone for all people in the Commonwealth of Massachusetts. *(D)*

MMS House of Delegates, 4/29/17
(Items 2, 3, 5 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 4/28/18)

The MMS will oppose legislation that would require prescribers of opioids to provide their patients with less than one week of medication. *(D)*

(Approved MMS Board of Trustees, 3/9/16)
Accepted MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

Penicillin

National Penicillin Allergy Day, September 28, will be recognized by the Massachusetts Medical Society. *(HP)*
The Massachusetts Medical Society will promote penicillin allergy evaluation and appropriate delabeling. *(D)*

MMS House of Delegates, 12/9/23

The MMS will advocate that state and county inmates in Massachusetts with opioid use disorders have access to the full spectrum of evidenced-based recovery support services, including all medication-assisted treatments covered on the MassHealth formulary and transition plans for post-release care. *(D)*

MMS House of Delegates, 4/29/17
(Item 2 of Original Auto-Sunset; Time-Limited Directive Completed, 4/28/18)

Performance Enhancing Drugs
The Massachusetts Medical Society calls upon its members and all physicians to oppose the use of illicit or prohibited performance enhancing drugs for the purpose of trying to improve athletic performance or for any purpose other than that which is medically indicated. *(HP)*

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

Personal Medication Lists
The MMS will work with the appropriate entities to track developments regarding accessing patients' personal medication lists by physicians and patients. *(D)*

MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Pharmacy Benefit Managers/Weekend, Holiday Availability
The Massachusetts Medical Society adopts the following adapted from American Medical Association policy:

The MMS will work with pharmacy benefit managers (PBMs), health insurers, and pharmacists to address the problem of patients, discharged by a health care facility on a weekend or holiday, being denied access to vital medications because the patient's health insurance carrier or applicable PBM does not have staff available on weekends or holidays to resolve coverage and/or formulary issues. (D)

MMS House of Delegates, 12/2/17

Prescription Marketing
The MMS will encourage all Massachusetts medical schools and residency programs to educate their students and resident physicians on the possible effects of pharmaceutical, device, and equipment marketing and advertising on care of patients, on various ethical policies on gifts to physicians from industry, and on alternative unbiased sources of information about pharmaceutical products, device, and equipment.

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for One Year Pending Review at A-24)

Prescription Prices
The MMS will include retail pharmacies, electronic pharmacy networks, and health plans in advocacy efforts supporting drug price transparency for health care providers and patients. *(D)*

The MMS will work with the AMA and any other relevant organizations to advocate for state and federal legislation requiring transparency of medication price and out-of-pocket costs for prescription medications at retail pharmacies. *(D)*

The MMS will encourage the AMA to work with insurance companies, retail pharmacies, state and federal governments, and any other relevant organizations, to create a national database accessible to health care providers and patients that lists medication price and after-insurance out-of-pocket costs for prescription medications. *(D)*

MMS House of Delegates, 4/28/18

The MMS will advocate for the Federal Trade Commission to limit anti-competitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through the manipulation of patent protections and abuse of regulatory exclusivity incentives. *(D)*

The MMS will advocate for prescription drug price transparency from pharmaceutical companies, pharmacy benefit managers, and health insurance companies. *(D)*

The MMS will advocate for monitoring of relationships between pharmacy benefits managers and the pharmaceutical industry, and discourage arrangements that cause an increased cost, or decreased availability, of prescription drugs. *(D)*

The MMS will advocate at the Massachusetts State House and Office of the Attorney General to bring attention to rises in drug prices and initiate patient protection actions regarding excessive drug pricing. *(D)*

MMS House of Delegates, 12/5/15
Reaffirmed MMS House of Delegates, 5/21/22

*The MMS will work toward eliminating Medicare prohibition on drug price negotiation. *(D)*

MMS House of Delegates, 12/6/14
Reaffirmed MMS House of Delegates, 12/5/15
*(*Reaffirmation was part of 12/15 item above)*
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society supports legislation to create a voluntary negotiated price reduction program with pharmaceutical companies that lowers prescription drug prices in order to make them affordable for the citizens of the Commonwealth of Massachusetts. (HP*)*

MMS House of Delegates, 5/2/03
Reaffirmed, MMs House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society supports federal legislation to authorize waivers for state demonstration projects to allow states to negotiate and purchase drugs on behalf of Medicare Part D beneficiaries utilizing existing revenues, and to create and implement alternative prescription drug programs for beneficiaries. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Prescription Writing/E-Prescribing

The Massachusetts Medical Society opposes psychologists obtaining prescription privileges in Massachusetts. *(HP)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Return or Recycling of Unused and/or Expired Medications

The MMS will advocate for new legislation to restore repealed legislation that allows the recycling of nursing home drugs that are unused, sealed, and dated. *(D)*

The MMS will advocate for legislation to enact prescription drug donation that allows unused, sealed, and dated medications to be directed by physician offices and clinics to patients in need who are uninsured or underinsured. *(D)*

The MMS will advocate for legislation specific to cancer programs and clinics to accept and recycle cancer-specific drugs to patients in need who are uninsured or underinsured. *(D)*

MMS House of Delegates, 4/29/17

The Massachusetts Medical Society supports the policy that all unused nursing home drugs, which are sealed and dated, be returned for credit.

The Massachusetts Medical Society, in collaboration with the Massachusetts chapter of the American Medical Directors Association and the Massachusetts chapter of the American Geriatric Society, urges the Massachusetts Department of Public Health to expand its current medication return list. *(D)*

The Massachusetts Medical Society urges Massachusetts Congressional members to draft legislation supporting the recycling of unused nursing home drugs, which are sealed and dated. *(D)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Item 1: Reaffirmed MMS House of Delegates, 5/14/10
Items 2 and 3: Amended and Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Sharing of Prescribing Data
The Massachusetts Medical Society will investigate legal, regulatory, legislative, or other approaches and take appropriate action to ban the sharing of individual providers' prescribing data by pharmacies, hospitals, insurers, or other entities with companies not involved in legitimate peer-review or utilization-review activities. *(D)*

MMS House of Delegates, 11/4/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Misuse *(Please Also See Opioids/Nasal Naloxone)*
The MMS recognizes substance use disorder as a chronic relapsing disease frequently accompanied by psychiatric comorbidities and genetic susceptibility. The MMS supports legislative and policy efforts that reduce conviction and incarceration solely for personal possession and illicit use of drugs and supports increased access to harm reduction services and all forms of treatment. Furthermore, the MMS is opposed to penalizing or incarcerating people with substance use disorders on the basis of relapse, and/or failure to meet the conditions established by courts and other related entities that conflict with principles of evidence-based care of substance use disorders. *(HP)*

MMS House of Delegates, 5/4/19

The MMS will advocate for and advance research into any harms, benefits, and/or efficacy of any involuntary commitment solely related to substance-use disorder. *(D)*

The MMS will oppose involuntary civil commitment of persons for reasons solely related to substance-use disorder without judicial involvement. *(D)*

The MMS will work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. *(D)*

The MMS will advocate that the American Medical Association oppose further expansions of authority to involuntary civil commitment of persons for reasons solely related to substance-use disorder without judicial involvement in Massachusetts and nationally. *(D)*

The MMS will advocate to limit the practice of involuntary civil-commitment for reasons solely related to substance-use disorder in Massachusetts in furtherance of health, ethical, and patients' rights imperatives. *(D)*

The MMS will advocate that the American Medical Association work to advance policy and programmatic efforts to address gaps in voluntary substance-use treatment services. *(D)*

MMS House of Delegates, 4/28/18

The MMS will advocate that all persons involuntarily civilly committed in Massachusetts for reasons related to substance-use disorder be confined only in facilities monitored and approved of by the Department of Public Health or Department of Mental Health, and be subject only to treatment consistent with accepted medical guidelines. *(D)*

The MMS will advocate to the Department of Public Health and Department of Mental Health to standardize and increase the effectiveness and quality of the treatment of persons involuntarily civilly committed for reasons related to substance-use disorder, in accordance with the best evidence-based medical standards of care. *(D)*

MMS House of Delegates, 4/28/18

The MMS recognizes that addiction, equivalent to a severe substance use disorder, is a chronic, relapsing brain disease. *(HP)*

The MMS supports efforts to educate physicians and physicians-in-training about pain management, principles for safe opioid prescribing, prevention of substance use disorder, identification of substance use disorder, treatment of substance use disorder, and referring patients to appropriate treatment. *(HP/D)*

The MMS will work with appropriate public and private entities to increase access to services for individuals with substance use disorder. *(D)*

The MMS will work with physicians, including those specializing in substance use disorder, to develop ways to increase access to treatment for individuals with substance use disorder. *(D)*

The MMS supports efforts to educate physicians and physicians-in-training about treatment options for patients with substance use disorder in primary care and other settings and encourage further education around medication-assisted treatment and other forms of treatment. *(HP/D)*

MMS House of Delegates, 5/2/03
Reaffirmed and Item 3 Amended and Reaffirmed MMS House of Delegates 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

The MMS will work with the Department of Public Health, the legislature, and other appropriate state agencies or nonprofit entities, to advocate for the statewide expansion of pre-booking jail diversion programs that redirect criminally-involved, eligible, non-violent individuals with substance use disorders to treatment programs. *(D)*
(Approved MMS Board of Trustees, 3/8/17)
Accepted MMS House of Delegates, 4/29/17

The MMS supports the state-wide implementation of accessible jail diversion programs for individuals with substance-use disorders. *(HP)*

The MMS will work with the legislature, the Department of Public Health, and other appropriate agencies to advocate for expanded government funding to substance-use disorder treatment programs with the intention of expanding capacity. *(D)*
MMS House of Delegates, 5/7/16
(Item 1 Reaffirmed 1 Year Pending Review at A-24)
Item 2 Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society encourages physicians to continue to take immediate initiative in diagnosing drug/alcohol use disorder as early as possible in the disease process to prevent job and family impairment, and make appropriate intervention with treatment and education of the individual patient. The Massachusetts Medical Society voices its commitment to involve physicians in finding solutions to the complex medical and social problems of substance use disorder and encourages physicians to continue to work with other concerned community agencies drawn from such fields as law, social work, psychology, public health, education and religion. *(HP)*

MMS Council, 10/8/86
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

PROFESSIONAL LIABILITY

ERISA

The Massachusetts Medical Society (MMS) continues its support of federal ERISA preemption repeal efforts, with priority given to repealing those provisions preempting state patient protection legislation. *(HP)*

The MMS continues to seek comprehensive federal legislation that reforms tort liability. *(HP)*

The MMS continues to seek state tort reform with regard to joint and several liability. *(HP)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society shall work with the American Medical Association state Advocacy Resource Center which has developed model state legislation to end ERISA preemption of state liability law in Massachusetts and lobby Massachusetts Congressional Representatives to support this. *(D)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Excess Professional Liability Insurance

It is the policy of the Massachusetts Medical Society that liability insurance in excess of that required for licensure by the Massachusetts Board of Registration in Medicine should not be a requirement for participation in health insurance plans, membership on hospital medical staffs, or any other purpose, and that the appropriate amount of any supplemental liability insurance should remain the purview of the individual physician. *(HP)*

MMS House of Delegates, 12/5/20

In order to enhance freedom of choice in the selection of medical professional liability insurance coverage, the Massachusetts Medical Society will advocate with all health insurance plans, hospital staffs, and other pertinent health care entities that any mandatory malpractice insurance coverage limit requirement higher than the state minimum should be eliminated. *(D)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Communication, Apology, and Resolution Programs

The MMS will advocate with appropriate stakeholders for the implementation of communication, apology, and resolution programs at hospitals, health care organizations, and medical practices across Massachusetts as the preferred approach to address adverse events. These programs shall include open communication with patients and families when unanticipated adverse outcomes occur, an investigation to determine and explain what happened, efforts to prevent recurrences and improve patient safety, a sincere apology, and where appropriate, an offer of timely and fair financial compensation. *(D)*

The MMS will advocate with appropriate stakeholders for the creation of robust peer support programs, including just-in-time coaching and emotional support for clinicians to help them communicate with patients about adverse events and throughout the resolution process. *(D)*

MMS House of Delegates, 5/4/19

Medical Malpractice Tribunal

The Massachusetts Medical Society will work to promote to its members and other physicians licensed in Massachusetts the value of the Medical Malpractice Tribunal. Such promotion could include, but need not be limited to:

a. Updating the online video explaining the tribunal and its role
b. Publishing a brochure about the tribunal to distribute to members and others
c. Article placement in *Vital Signs* and *Vital Signs This Week*
d. Advertising in *Vital Signs*

(D)

The Massachusetts Medical Society will work to recruit physicians licensed in Massachusetts to join a database of physicians willing to serve on a Medical Malpractice Tribunal. Such recruitment efforts could include, but need not be limited to:

a. Publishing a brochure about the tribunal to distribute to members and others
b. Article placement in *Vital Signs* and *Vital Signs This Week*
c. Advertising in *Vital Signs*
d. Working with the Board of Registration in Medicine to ask that they add a way for physicians to enroll when applying for licensure or relicensure
e. Working with medical malpractice insurance providers to ask their insureds to enroll

(D)

MMS House of Delegates, 12/2/17
(Item 3 of Original – Study- Auto-Sunset: Time-Specific Directive Completed MMS House of Delegates, 4/28/18)

Personal Property Exemption

The MMS will seek support from other interested groups, such as the Professional Liability Foundation, Ltd., and other professional membership organizations for efforts advocating for appropriate state and federal legislation: (1) amendment to M.G.L. c. 235 §34, which currently carves out personal property exemptions from execution in Massachusetts, and M.G.L. c. 235 §34A, governing exemption of annuities, pensions, profit sharing, or retirement plans from attachment or execution; and (2) amendment to other relevant state and federal laws governing personal property exemptions from execution, bankruptcy, and other modes of asset protection in order to protect the personal property of a medical professional up to an amount equal to the face value amount of a medical professional's liability insurance policy, insuring the damages at issue in a medical professional liability action. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Item1 and 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Physician Expert Witnesses

The Massachusetts Medical Society (MMS) adopts the following Expert Witness Testimony Standards, applicable to all physicians who testify as expert witnesses in professional liability cases in Massachusetts:

1. The physician expert witness must hold a current, valid, nonrestricted medical license.
2. The physician expert witness must be board certified in the same specialty as the defendant physician when providing expert testimony on the standard of care provided by the defendant, or board certified in their specialty when providing any other relevant expert testimony in the case. Board certification shall be with a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association.
3. The physician expert witness must be actively engaged in the clinical practice of medicine.
4. The physician expert witness must be aware of and comply with the American Medical Association's (AMA) policies on Medical Testimony, False Testimony, Peer Review of Medical Expert Witness Testimony, Expert Witness Testimony, AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys, and other applicable expert witness testimony standards, guidelines, principles, and codes of ethics established by the American Medical Association.
5. The physician expert witness must acknowledge and comply with expert witness testimony standards, guidelines, principles, and codes of ethics established by the national specialty society for the testifying physician's specialty, and sign, if such exists, an affirmation of compliance.
6. The physician must be available at trial if rendering an opinion at the tribunal stage of the proceedings.
7. The physician expert witness must be aware that the Federation of State Medical Boards defines false, fraudulent, or deceptive testimony as unprofessional conduct, and that such testimony may be actionable by the Massachusetts Board of Registration in Medicine or any other state licensing boards with whom the physician expert witness holds licenses to practice medicine.
8. The physician expert witness must be willing to submit transcripts of depositions and courtroom testimony to independent peer review by the appropriate specialty society.

(HP)

The MMS will collaborate with appropriate legal representatives, Massachusetts professional liability insurers, and the Massachusetts Board of Registration in Medicine for purposes of implementing the Expert Witness Testimony Standards

in the form of MMS policy, an affirmation statement, and/or by other useful and effective means, to improve the quality of clinical evidence introduced at all stages of the litigation process. *(D)*

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11
Item 2 of Original Reaffirmed MMS House of Delegates, 4/28/18
Amended and Reaffirmed MMS House of Delegates, 5/4/19

The Massachusetts Medical Society will continue to advocate for legislation which requires that physician expert witnesses testifying in medical professional liability cases venued in the Commonwealth of Massachusetts must possess the following qualifications: (1) Hold a non-restricted medical license; (2) Be board certified in the same relevant specialty as the defendant physician; (3) Be actively practicing in the same specialty as the defendant physician; (4) Be available at trial if serving as the expert at the tribunal stage of the proceedings. *(D)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Tort Reform
The Massachusetts Medical Society will work diligently to assure that significant changes in state payment methodology are associated with significant and meaningful professional liability reforms. *(D)*

MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

PROFILING, TIERING, AND PHYSICIAN PERFORMANCE

Principles/Policy for Measuring and Rewarding Physician Performance
The Massachusetts Medical Society adopts as amended the MMS Guidelines for Measuring, Reporting, and Rewarding Physician Performance adopted at A-05 and reaffirmed at A-12, and the MMS Principles on Physician Profiling adopted at I-98, and reaffirmed at A-05 and A-12 and I-14, to read as follows:

Principles for Measuring and Rewarding Physician Performance

Increasingly, physicians are being judged by systematic measurement and reporting of their performance on selected quality indicators, by patient experiences with the care received, and by assessment of the appropriateness and cost-effectiveness of care. Quality improvement programs that have these goals should:
Use objective, well-validated, and clinically important measures of quality;
Ensure accurate and timely assessment of these measures;
Be available for all practicing physicians to participate in;
Provide for timely review of reports by involved physicians prior to public release;
Ensure that reports released to the public can be easily and accurately interpreted;
Make appropriate use of risk-adjustment and statistical methods when reports aim to compare performance among clinical practices or hospitals or make clear notation that population differences make direct comparisons difficult or impossible;
Use appropriate incentives to reward performance and stimulate continuous improvement in the quality of care being provided;
Be meaningful (difference in levels of performance between higher performance and lower performance is significant) and attainable;
Promote and facilitate the use of information technology (IT) tools including electronic health records (EHRs) to electronically capture data.

A. Goals of Performance Measurement
Improving performance measurement is an important component of improving health equity. Consideration of health equity must be at the forefront of performance measurement.
The primary goal of performance measurement is to improve the quality of health care by providing physicians with meaningful information on their clinical performances. Hence, success should be measured by evidence of improvement over time in the structures, processes, and outcomes of care.
Other important goals are to ensure physician accountability to the needs of health care consumers and accrediting and regulatory entities.

Physician leadership is essential in developing and implementing performance measurement activities to ensure their clinical relevance and to help inform patients and the community about aspects of health care that are particularly important to physicians.
Performance measurement must address local, as well as regional and national, priorities if local needs are to be satisfied and active physician participation is to be assured.

B. General Principles of Physician Performance Measurement
Performance measures should be clinically relevant to the populations served by individual physician or group practice being evaluated. Markers of importance include high prevalence; significant impacts on mortality, morbidity, or costs; and high degrees of practice variation where variations have well-documented relationships to health outcomes.
Performance measurement should always be at the group level or higher, and only at the individual physician level if there is a meaningful minimum number of patients or events. Where responsibility for care is shared, the team, group practice, or hospital service should be the unit of evaluation. When attribution is uncertain, evaluation should be at the higher level of aggregation.
Performance measures should, to the maximum extent possible, be firmly grounded in scientific evidence. Where the science base is inadequate, professional consensus may be substituted. In either case, sources of support for the measure and their validity should be fully documented and readily accessible.
The process for selecting the range of performance measures to be included should take into account the perspectives of all involved parties including physicians, patients, health plans, provider organizations, employers, payers, and regulatory agencies.
Quality measures must be clinically important, prospectively defined, and designed for objective and accurate measurement for patient populations. They should be evidence based and directed at medical specialists as well as primary care physicians. Measures aimed at health care outcomes are preferred. Measures should be case mix adjusted and account for known factors related to health equity. Measures aimed at processes of care are also important if they are closely linked to improved outcomes.
The costs of quality measurement can be considerable. Costs should be justified by tangible evidence of resulting improvements in health care quality and equity and/or savings in the costs of health care. Measures of cost should include the added clerical burdens on physician practices and physician organizations.
Physicians should be actively engaged in all aspects of quality measurement in developing quality measures, implementing and monitoring quality measurement, and reporting results to practices and the public. To these ends, physicians should work in close collaboration with payers, quality measurement organizations, and regulators.
C. Development of a Performance Measurement Program
Development of effective performance measurement programs requires close collaboration among physicians, their health care organizations, payers, and regulatory agencies.
Expected benefits of performance measurement should be weighed against the burden and costs for the program as a whole, and for each performance measure. The value of performance measurement will be increased by the use of standardized measures and methods, avoidance of duplication of effort, and steps to ensure the accuracy and usefulness of results.
Ongoing performance measurement activities should be regularly assessed for continual validity given current scientific evidence. These evaluations should focus on the choice of performance measures, data collection and analysis strategies, the accuracy of the results obtained, and the appropriateness of interpretation of results.
Organizations that conduct performance measurement (provider organizations and vendors) should disclose fully their performance measurement objectives, policies, and methods, and make these readily accessible to both the physicians being assessed and the public.
The burden and costs of performance measurement should be fairly allocated among those who will potentially benefit including physicians, patients, health plans, payers, employers, and regulatory agencies.

1. Characteristics of Performance Measures
Measures should be based on data available to the clinician in the real-time clinical setting and should have clear actionable data to improve the quality of care.
Measures should be standardized and capable of systematic and objective measurement. Relevant data sources must be available, accurate, and reasonably complete.
To the extent possible, measures should rely on data that are routinely collected during usual patient care.
The burden of data collection for a measure should be reasonable.
Measures should be updated at regular intervals to reflect changes in medical knowledge or the norms of practice.
Measures of clinical outcomes should be risk-adjusted so that results appropriately reflect patients' severity of illness at the time of presentation or time of clinical action. Methods used for risk-adjustment should be accurate at all levels of

severity of the illness. The data derived from all modalities of care including in person, audio-only, visual telephonic care and remote monitoring should be included in the risk-adjustment analysis.
Measures and associated analytic methods should be clearly defined and fully disclosed to necessary parties. Measures based on un-disclosed algorithms or software are not acceptable.

2. Types of Performance Measures
Clinical outcome measures should be clearly related to processes of care that are under the control of the primary care physician or primary group practice or appropriate specialist, and can be modified to affect the outcome.
Process measures should be clearly linked by scientific evidence to direct effects on patient outcomes. They usually relate to diagnostic and treatment decisions but may relate to access to care or compliance with care regimens.
Patient perceptions of and satisfaction with the quality of services are important.
Patients are often the best witnesses to assess the total experience of their care.
Resource use and cost measures should be supported by evidence that patient care will not be adversely affected and expectations for benchmarks should be appropriate. When efficiency measures are used, quality measures should be used in conjunction with such measures to ensure there is appropriate utilization.
The primary purpose of performance measurement related to resource use and costs should be to raise awareness and inform quality improvement activities. Results should not be used for punitive purposes except in cases of flagrant overuse or clear waste.

3. Data Sources
Each data source should meet explicit standards of accuracy and completeness if valid comparisons are to be made among physicians or practices.
The data source should be appropriate to the performance measure being examined.
The data source should be readily available in all practices or health plans being compared.

4. Data Collection
Data collection protocols should be explicit, as objective as possible, and limited to essential items of data.
Data collection from medical records or by survey should be performed by persons skilled in the methodology. Ideally, these individuals should be selected and reimbursed in a manner that will optimize objectivity and minimize bias.

5. Data Analysis
The level of analysis (individual physician, group practice, or health plan) should be appropriate to the ability of data to support meaningful analyses and the intended use of the report. Sample sizes of events or cases that are too small to support analyses at the level of the individual physician may be useful for internal quality improvement but should not be released to the public.
Analyses should be planned and conducted by individuals who are skilled in appropriate analytic techniques.
Analytic techniques should be appropriate to the objectives of the analysis and the database.
Reports should emphasize important differences between the entities being compared or time trends in performance, and include clear statements about the statistical significance and clinical importance of results.
Reports that are to be released to the public should be based on adequate sample sizes and accurate data, and meet high standards of statistical validity. Independent external audits should be performed prior to release.
Reports that are for internal discussion/use in quality improvement activities can be based on smaller sample sizes and may not require formal statistical analysis.
Methods of analyses should be described in sufficient detail that results can be easily understood and, if necessary, reproduced.

6. Risk-Adjustment
Adequate risk-adjustment is essential to achieving valid comparisons among physicians, practices, or health plans on clinical outcomes and the appropriateness of decisions to perform surgical or diagnostic procedures.
Adjustment for selected patient characteristics such as age, gender, race and ethnicity, and risk factors for the disease are important for process measures (e.g., mammographic screening for breast cancer). Every effort should be made to identify gender, race, and ethnicity data.
Risk-adjustment models should be carefully tested before they are used and should have demonstrated good calibration between predicted and actual outcomes at all levels of severity of illness. Generic risk-adjustment models can be used if they have been demonstrated to be valid for the particular condition and the particular type of clinical setting.
The risk-adjustment methodology should be well-documented and open to inspection, preferably published in the peer-reviewed medical literature.

D. Internal Distribution and Use of Performance Reports within Physician Organizations

Physicians and physician groups being assessed should be the first to receive all reports that measure their performance. They should be given an opportunity to review and comment on reports prior to external release. In particular, physician "outliers" on a measure should be contacted to detect any unusual circumstances that explain the result. Documented errors should be corrected, and substantive comments or explanations of variability should be used to determine whether external release is appropriate and if so, the comments should be included with the report.

All reports should be clear and unambiguous and accompanied by materials that facilitate proper interpretation. Reports, when possible, should be protected under peer review.

Performance reports used for internal quality improvement should remain confidential between the physician or physician group being measured and their immediate supervisors. Such reports should be protected from disclosure by peer review regulations, whenever possible.

E. Public Reporting of Physician Performance

Reports for public release must meet high standards for accuracy and statistical validity. Reports should not be released when there are too few cases to support a meaningful analysis. They should receive timely review by involved practices prior to release, and should be corrected for discovered errors or risks of misinterpretation. Particular attention should be given to ensure that correct attribution is made to physician practices involved in physician performance reporting.

Reports that compare performance of physicians or practices to each other or to benchmarks must avoid using subjective language.

Reports should embrace components of diversity, equity, and inclusion. They must also pay careful attention to differences in sociodemographic and socioeconomic variables that may affect patient attitudes toward health care and adherence to recommendations of their physicians.

Public distribution of practice level performance results should only be reported if the results meet volume standards and are clinically meaningful by the necessary parties as defined by the responsibilities of the entity and the content of the report. Criteria for external distribution, including rules governing confidentiality of content, should be explicitly stated and agreed to by all involved parties.

Organizations that use physician performance reports should publicly disclose the types of information they need and how this information will be used to improve the quality of health care.

Reports intended for public release should meet higher standards of accuracy, reliability, and statistical validity than those intended for internal discussion/use only. Reports should not be released when there are too few cases to support a meaningful analysis. Appropriate risk adjustment of results is essential. All reports should be clear and unambiguous and accompanied by materials that facilitate proper interpretation. Reports should be protected from discovery during legal proceedings.

F. Frequency of Performance Reports

The frequency of reports depends on the intended purpose. If the goal is to achieve behavior change and quality improvement, frequent reinforcement by quarterly reports may be required. Annual reports are usually sufficient for comparisons among health plans or to satisfy accrediting agencies.

The burden of data collection and other costs of performance measurement will be limiting factors both for the selection of performance measures and the frequency of reports.

G. Assessing the Quality of Patient-Physician Relationships

Quality-measurement programs should be directed at supporting and improving the value of care to the patient. To these ends, they must reflect the vital importance of sound medical judgments as well as adherence to defined guidelines.

Programs should protect and improve access to high-quality health care for all patients. The quality measurement program should be sensitive to all aspects of diversity, equity, and inclusion, and to all complex medical conditions.

Patient experience surveys should be a part of the quality measurement program and should include information to assess health care disparities.

Programs should aim to achieve equity in quality assessment for patients and their physicians, regardless of the setting in which care is delivered or the location of the population served (for example, inner city or rural areas).

Programs should be "risk-adjusted."

Paying for Performance (P4P)

Criteria, methodology, and background data for P4P on measures of quality and cost should be transparent to all involved.

Practices involved with these incentives should have a period of pay for reporting before they are incentivized in a pay for performance model.

Pay for performance metrics should enhance the delivery of care by identifying gaps in care and inequities in care.

Funding of the infrastructure to improve care should not come from a redistribution of physician reimbursement. P4P funding should not come from a redistribution of current physician and other health care provider reimbursement. P4P incentives should be aligned and standardized across payers and physician practices, while taking into consideration the patient population. Specific measures should be applied only to those patients to whom the peer-reviewed medical evidence is applicable, including demographic characteristics, clinical characteristics, clinical significance, and life expectancy.
(HP)

MMS House of Delegates, 12/6/14
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society will advocate to payers that pay-for-performance statistics shall apply only to patients to whom the peer-reviewed medical evidence is applicable, including such criteria as: demographic characteristics, clinical characteristics, clinical significance, and life expectancy. *(D)*

MMS House of Delegates, 12/7/13
(Item 2 of Original: Auto- Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/6/14)
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Tiering
The Massachusetts Medical Society (MMS) opposes implementation of physician tiering mechanisms as cost containment or quality assurance programs unless and until the underlying measurements and methodology are validated. *(HP)*

MMS House of Delegates, 11/04/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

PUBLIC HEALTH

Antibiotics/Agricultural Animals
The Massachusetts Medical Society supports legislation and regulation(s) that prohibit use of non-therapeutic antibiotics in farm animals. *(D)*

MMS House of Delegates, 12/7/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20
(Item 1 of Original: Sunset MMS House of Delegates, 12/5/20)

The Massachusetts Medical Society (MMS) is supportive of the reduction of overall antibiotic use in agricultural animals raised in the United States and in animals from which meat or other food products are imported to the United States. *(HP)*

MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Civic Voting
The MMS acknowledges civic voting as a dimension of public health and potential driver of health outcomes. *(HP)*

The MMS supports patient voting in the health system including promotion of optional, non-partisan voting resources regarding registration, date and polling locations, early voting deadlines, and absentee ballot requests. *(HP)*

MMS House of Delegates, 5/8/21

Concussion
The Massachusetts Medical Society adopts the following adapted policies/directives from the American Medical Association and the American Association of Neurological Surgeons:

The MMS will continue to work:

a. With other organizations to increase athletic safety by promoting concussion awareness, including the fact that even mild cases of traumatic brain injury may have serious and prolonged consequences
b. With other organizations to develop a program of public education designed to underscore the importance of prevention, diagnosis, and proper treatment of concussion and other brain-related injuries
c. With appropriate state and specialty medical societies to enhance opportunities for continuing medical education

d. With sports-governing bodies, as well as players, coaches and administrators, to ensure that an athlete who exhibits symptoms associated with these types of injuries is properly evaluated, treated, and cleared before they are allowed to return and participate in sports

(D)

The MMS supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations. *(HP)*

The MMS encourages research on sports-related concussions, such as to:

a. Identify determinants of concussion
b. Assess the short- and long-term consequences of repetitive head impacts
c. Develop and evaluate risk-reduction measures
d. Develop methods to improve diagnostic accuracy, reduce the dependence on self-reporting, and inform better guidelines *(HP)*

MMS House of Delegates, 12/3/16
(Reaffirmed for 1 Year Pending Review at A-24)

Elder Care *(Please see additional policy under Healthy Lifestyle/Aging)*
The Massachusetts Medical Society will disseminate information to physicians and the public, through its existing communications vehicles, about services offered by the state Executive Office of Elder Affairs for frail elders. *(D)*

The Massachusetts Medical Society will educate its members, through existing communications channels, about challenges faced by family caregivers. *(D)*

MMS House of Delegates, 4/29/17

Emergency Preparedness/Bleeding Control
The MMS will implement a three-year bleeding control "train the trainer" demonstration project to provide hands-on regional instruction for physicians and allied health professionals in bleeding control, wound packing, and tourniquet application in order to increase the number of individuals trained in bleeding control in the Commonwealth. *(D)*

The MMS will develop a comprehensive bleeding control resource and information page on its website to support the demonstration project and increase bleeding control awareness. *(D)*

The MMS will review and assess the efficacy and impact of the bleeding control "train the trainer" demonstration project. *(D)*

MMS House of Delegates, 12/1/18

The Massachusetts Medical Society recognizes that emergency preparedness awareness and disaster response training are an essential part of public health and will work to engage physicians in preparedness efforts because of the critical role they play in limiting the medical, including psychological, impact of disasters on individuals and the community. *(HP)*

The Massachusetts Medical Society provides emergency preparedness and disaster response resources for physicians in order to increase awareness and knowledge of emergency preparedness structure, response, agencies, and trainings. *(HP)*

MMS House of Delegates, 12/7/13
Reaffirmed MMS House of Delegates 12/5/20
(Item 2 of Original): Amended and Reaffirmed MMS House of Delegates 12/5/20

The Massachusetts Medical Society (MMS) will continue to work in collaboration with appropriate local, state, and federal public health agencies and others responsible for disaster management to develop and implement a comprehensive and integrated education, communications, and strategic response plan for the physician community to protect the health and safety of our patients and our communities in the event of a disaster. *(D)*

The MMS will emphasize and advocate for the importance of routine child and adult immunizations, such as tetanus and influenza, as a first step in preparedness. *(D)*

Other basic public health functions, such as statewide trauma care and hospital capacity, and post trauma care and rehabilitation will be included in the preparedness planning process and final plans. *(D)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

The Massachusetts Medical Society (MMS) recognizes the reality that an infectious disease outbreak, terrorist attack, or other catastrophic event can occur at any moment with the potential to cause severe morbidity and mortality. The MMS is dedicated to enhancing and continually improving the planning, mitigation, response and recovery activities needed to protect the health of the Commonwealth. *(HP)*

The MMS Committee on Preparedness will work in collaboration with local, state, and federal public health agencies, hospitals, and others responsible for emergency preparedness and disaster management, on the development, coordination, and facilitation of educational initiatives, communications systems, and integrated response plans for the medical community to minimize the consequences of natural or man-made disasters and other public health emergencies. The Committee on Preparedness will incorporate into its work advocacy for adequate resources, for populations with special medical needs during disasters or those that have been historically marginalized or made vulnerable, and for community engagement in all phases of preparedness planning. *(D)*

The Committee on Preparedness will endeavor to assist physicians and other health care professionals in their preparedness efforts with planning and response tools and other resources, and will encourage them to volunteer with MA Responds, the Massachusetts centralized volunteer management system, in order to enhance the state's capacity to respond to health emergencies. *(D)*

MMS House of Delegates, 11/17/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Fetal and Infant Health *(Please also See Policy Under Prescription and Non-prescription Drugs, Substance Use and Misuse)*

The MMS supports newborn screening that is evidence-based. *(HP)*

The MMS will advocate for support and systems for newborn congenital cytomegalovirus (cCMV) follow up and treatment. *(D)*

The MMS supports further study of appropriate screening for congenital cytomegalovirus (cCMV) in newborns. *(HP)*
MMS House of Delegates, 12/9/23

The MMS acknowledges the discriminatory harm that strict mandated reporting for all substance exposed newborns causes for the parent-infant dyad. (*HP*)

The MMS will advocate for harm-reduction efforts aimed toward promoting equity in our mandated reporting framework for all substance-exposed newborns. (*D*)

MMS House of Delegates, 5/21/22

The MMS supports the timely, systematic monitoring of fetal and infant mortality in Massachusetts. *(HP)*

The MMS will work with the appropriate stakeholders, regulators, and/or policymakers to advocate for the establishment of a timely, systematic monitoring of fetal and infant mortality in Massachusetts. *(D)*

MMS House of Delegates, 4/28/18

Food Security/Food is Medicine
The MMS supports the adoption and funding of universally free school meals. *(HP)*

The MMS will advocate for the adoption and funding of universally free school meals. *(D)*

MMS House of Delegates, 5/21/22

The MMS supports *food is medicine* interventions that consist of healthy foods that are nutritionally tailored to meet the specific needs of patients living with or at risk for serious health conditions affected by diet and/or food insecurity. *(HP)*

The MMS will support legislative and regulatory efforts that advance *food is medicine* interventions as part of a treatment plan for patients living with or at risk for health conditions affected by diet and/or food insecurity. *(D)*

MMS House of Delegates, 12/5/20

The MMS encourages routine food insecurity screening by health care providers, their organizations, and schools, with validated food insecurity screening tools or larger screening sets for social determinants of health that incorporate screening for food insecurity. *(HP)*

The MMS encourages health practices to adopt as policy screening all patients for food insecurity as a critical component of clinical care, especially in underserved communities. *(HP)*

MMS House of Delegates, 4/28/18

Gambling

The Massachusetts Medical Society will advocate and educate regarding the adverse public health effects of gambling as a service to our legislators and other parties interested in objective and factual data. *(D)*

That if casino gambling were to move forward, then the MMS shall advocate for dedicated revenues, at adequate funding levels, for the treatment of public health problems (e.g., alcohol, substance abuse and gambling addictions) which may be aggravated by the presence of casino gambling. *(D)*

MMS House of Delegates, 12/4/10
Reaffirmed MMS House of Delegates, 4/29/17

That in considering the impact of casino gambling, the Legislature should acknowledge the downside of gambling, particularly the negative public health consequences, and should dedicate funding and other appropriate initiatives to mitigate those consequences. *(HP)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society (MMS) encourages physicians to advise their patients of the addictive potential of gambling. The MMS encourages Massachusetts Government, which operates gambling programs in the Commonwealth of Massachusetts, to provide a fixed percentage of the revenue from gambling for education, prevention, and treatment of gambling addiction.

The MMS encourages the Massachusetts Government and any private enterprise, which operates gambling programs in the Commonwealth of Massachusetts, to affix to all lottery tickets, displays at all lottery ticket counters, and at all gambling establishments, a culturally appropriate warning sign in multiple languages that states, “You may become addicted to gambling! Gambling a problem? For help call the gambling hotline: 1-800-426-1234.”

MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/11/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

Genetically Engineered Foods
The MMS supports mandatory premarket systematic safety assessments of bioengineered foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in bioengineered foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens. The FDA is urged to remain alert to new data on the health consequences of bioengineered foods and update its regulatory policies accordingly. *(HP)*

The MMS supports continued research into the potential consequences to the environment of bioengineered crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests; and (e) assessment of the agricultural impact of bioengineered foods, including the impact on farmers. *(HP)*

The MMS recognizes the many potential benefits offered by bioengineered crops and foods, does not support a moratorium on planting bioengineered crops, and encourages ongoing research developments in food biotechnology. *(HP)*

The MMS urges government, industry, consumer advocacy groups, and the scientific and medical communities to educate the public and improve the availability of unbiased information and research activities on bioengineered foods. *(HP)*

MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Hand Washing
The Massachusetts Medical Society advocates hand washing as a simple, safe, effective method to prevent infectious disease for the general population, and in particular prior to eating and preparing food, and after using the bathroom. *(HP)*
MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Health Care Needs of Sex-, Sexual-, and Gender-Diverse (SSGD) *Community (Please See Additional Policies under Nondiscrimination and Medical Education)*

The Massachusetts Medical Society (MMS):
(a) believes that providing inclusive, welcoming, and accepting care to patients of all genders, sexual orientations, identities, and anatomies is necessary to providing optimal patient care in health, as well as in illness; with the help of the SSGD community and through a cooperative effort between the physician and patient, effective progress can be made in treating the medical needs of the community

(b) believes that the appropriate collection of data on gender, sex, and sexual orientation facilitates the provision of appropriate medical care, thereby emphasizing the value of taking an adequate gender, anatomy, and sexual history

(c) is committed to taking a leadership role in:
(i) educating physicians on the current state of research and evidence-based guidelines in SSGD health, starting with undergraduate medical education, and also on being a part of continuing medical education
(ii) educating physicians to recognize the physical and psychological needs of their SSGD patients, on the social determinants of health specific to SSGD patients, dismantling the disparities in health faced by these patients including the intersectional effects of race and other underprivileged identities
(iii) encouraging the development of patient-centered education for members of the SSGD community around health optimization that is specific to their needs
(iv) encouraging physicians to listen to their SSGD patients' needs as they

improve their care models for their population; recognizing that their voices should be at the forefront of any work that is done to improve their health
(d) opposes the use of "reparative" or "conversion" therapies (including psychological, medical, or surgical therapies) based upon the assumption that diversities in the SSGD community are pathologies (e.g., mental and/or physical disorders) or based upon the a priori assumption that patients need to conform to social norms
(e) supports, in patients with sex trait variations (also termed intersex traits or differences of sex development), delaying medical interventions that would alter a patient's sexual or reproductive anatomy or potential, when possible, to allow for the patient to participate in the decision-making regarding any contemplated nonemergent intervention

(f) recognizes the research on transgender health that supports the evidence-based practices of social, medical, and surgical transition

(g) supports parents in accessing patient-centered gender affirming care for transgender children and opposes any legislation that prevents parents from affirming their children in making these decisions

(h) supports SSGD youth in having equitable access to activities that are beneficial to health and wellness, such as sports and other cultural activities, and their ability to participate in such activities in a manner that aligns with their identity *(HP)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS will advocate for the inclusion of deidentified sexual orientation and gender identity (SOGI) data collection as part of COVID-19 reporting. *(D)*

The MMS will work with appropriate state officials and departments to appropriately implement deidentified SOGI data collection for future pandemic reporting. *(D)*

MMS House of Delegates, 5/8/21

The Massachusetts Medical Society affirms that transgender detainees or persons who are incarcerated should be allowed to be placed in facilities that are reflective of their affirmed gender identity regardless of surgical status, if they so choose. *(HP)*

MMS House of Delegates, 12/3/16
(Item 2 of Original: Auto-Sunset: Time-Limited Directive Completed, MMS House of Delegates, 12/2/17)
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society (MMS) will offer annually a scholarship related to lesbian, gay, bisexual, transgender, and queer (LGBTQ) matters (The LGBTQ Research Scholarship) made eligible to the medical schools and specialty training programs in the Commonwealth. The scholarships may be used for curriculum development or to produce research that address lesbian, gay, bisexual, transgender, queer health services, health outcomes, and health disparities. *(D)*

The LGBTQ Research Scholarship recipients will be required to present the outcomes of their efforts at the subsequent MMS Interim Meeting. *(D)*

(Replaced by New Policy) MMS House of Delegates, 5/4/19

The Massachusetts Medical Society encourages all hospitals to participate in ongoing institutional assessments of their policies and practices related to lesbian, gay, bisexual, and transgender patients and families using appropriate instruments so they can address areas in their current policies and procedures that need to be appropriately updated. *(D)*

MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Healthy Lifestyle/Aging
The MMS supports the evidence-based principles and interventions of lifestyle medicine, including healthy eating habits, regular exercise, managing stress, fostering healthy social relationships, sleep hygiene, and avoidance of risky substances for the prevention, treatment, and reversal of chronic diseases. *(HP)*

The MMS will actively promote the evidence-based principles and interventions of lifestyle medicine by directing members to currently available educational resources. *(D)*

MMS House of Delegates, 5/13/23

The MMS recommends that adults consume a diet higher in vegetables, fruits, whole grains, low- or non-fat dairy, seafood, legumes, and nuts; lower in red and processed meat; and low in sugar-sweetened foods and drinks and refined grains. *(HP)*

The MMS supports government-sanctioned guidelines outlining a diet higher in vegetables, fruits, whole grains, low- or non-fat dairy, seafood, legumes, and nuts; lower in red and processed meat; and low in sugar-sweetened foods and drinks and refined grains; as well as policy and regulations promoting the production and distribution of elements of such a diet. *(HP)*

The MMS recommends increased physical activity for all adults and supports policies and regulations to promote physical activity, such as safe neighborhoods in which to walk. *(HP)*

The MMS supports policy and regulations to promote maintenance of meaningful involvement of older adults in all spheres of social and work life, including employment, transportation, and housing. *(HP)*

MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The MMS will advocate for coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit. *(D)*

The MMS will advocate for policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly. *(D)*

The MMS will advocate for increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids. *(D)*

The MMS supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss. *(HP)*

(Approved MMS Board of Trustees, 9/15/21)
Accepted MMS House of Delegates, 12/4/21

Helmets
The Massachusetts Medical Society will continue to support wide access to and the wearing of bicycle helmets. *(D)*

The Massachusetts Medical Society will support public safety educational programs that encourage all people regardless of age to wear helmets and highly-visible clothing while bicycling. *(D)*

MMS House of Delegates, 12/6/14
Item 1: Reaffirmed MMS House of Delegates 5/8/21
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society (MMS) supports the use of helmets in skiers and snowboarders, particularly in children and adolescents. *(HP)*

MMS House of Delegates, 5/8/09
Item 1: Reaffirmed MMS House of Delegates, 5/7/16
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23
Item 2 of Original: Sunset MMS House of Delegates, 5/13/23

Homelessness/Camping Ordinances
The Massachusetts Medical Society supports the revision of anti-camping ordinances in Massachusetts in order to protect the health of homeless individuals. *(HP)*

MMS House of Delegates, 4/29/17

Housing Insecurity
The MMS will advocate for streamlined, timely, easily accessible, and equitable rental assistance, especially around emergency rental assistance during public health emergencies. *(D)*

The MMS will advocate for state payment of rents and utilities of those unable to pay during public health emergencies. *(D)*

The MMS will work with community stakeholders and advocate for the development of innovative alternative uses of public and private spaces and facilities during public health emergencies to accommodate those in need of shelter and adequate housing to prevent the spread of disease. *(D)*

The MMS will work with community and industry stakeholders to increase access to temporary affordable or free housing to assist with quarantine and isolation of all frontline workers in accordance with Department of Public Health guidelines (including but not limited to health care and nursing home employees, first responders, and staff in essential industries. *(D)*

MMS House of Delegates, 12/4/21

The MMS will advocate for increased public and private funding and legislation providing for equitable, accessible, affordable, safe, and stable housing. *(D)*

The MMS will work with community stakeholders to advocate for increased public and private funding for affordable housing units and creating transparent, equitable pathways for those seeking stable housing. *(D)*

The MMS will work with community organizations to advocate for policies and legislation around multimodal comprehensive approaches to vulnerable populations seeking housing by increasing supportive services, including but not limited to case management, health care, mental health and substance use disorder treatment, legal services, supportive services for families (e.g., educational, case management, legal services), and employment services. *(D)*

MMS House of Delegates 5/8/21

The MMS will work with community organizations to advocate for policies and legislation which reduce housing insecurity in Massachusetts. *(D)*

The MMS will work to support programs by other relevant stakeholders, such as, hospitals, and accountable care
organizations, that seek to prevent housing insecurity, prioritizing proposals designed and supported by the communities most affected by housing insecurity. *(D)*

The MMS recognizes the negative health effects of housing insecurity more broadly, and its disproportionate effect on communities of color and lower-income areas. *(HP)*

MMS House of Delegates, 12/5/20

Human Medicine, Veterinary Medicine, and Environmental Sciences
The Massachusetts Medical Society adopts the following statement from the Centers for Disease Control:

The MMS supports the One Health concept, which recognizes that the health of people is connected to the health of animals and the environment. One Health encourages a collaborative, multisectoral, and transdisciplinary approach — working at the local, regional, national, and global levels — with the goal of achieving optimal health outcomes recognizing the interconnection between people, animals, plants, and their shared environment. *(HP)*

MMS House of Delegates, 12/3/11
Adopted in lieu of Original MMS House of Delegates, 5/4/19

Impaired Drivers
The Massachusetts Medical Society supports initiatives that improve driving safety, such as periodic re-testing of drivers in increased-risk categories, promotion of alternative modes of transportation, and improved patient education about driving responsibly. *(HP)*

The Massachusetts Medical Society promotes education on the dangers of impaired and distracted driving in all its forms. *(HP)*

Amended and Reaffirmed, MMS House of Delegates, 4/29/17

The Massachusetts Medical Society supports initiatives that improve driving safety, such as periodic re-testing of drivers in increased-risk categories, promotion of alternative modes of transportation, and improved patient education about driving responsibly. *(HP)*

The Massachusetts Medical Society promotes education on the dangers of impaired and distracted driving in all its forms. *(HP)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Influenza Vaccination/Other Vaccinations (*Please See Additional Policy under Emergency Preparedness)*
That, in the context of a highly transmissible disease that poses significant medical risk for traditionally marginalized and/or vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians health care workers and family caregivers who have direct patient care responsibilities or potential direct exposure to a highly transmissible disease have an ethical obligation to accept immunization unless there is a documented medical contraindication to immunization of a physician, health care worker, or family caregiver, medical reason to not be immunized. In scenarios in which there is a documented medical contraindication to immunization of a physician, health care worker, or family caregiver, appropriate protective measures should be taken. *(HP)*

MMS House of Delegates, 12/5/15
Amended/Reaffirmed MMS House of Delegates, 5/13/23

The MMS supports efforts by the Massachusetts Department of Public Health (DPH) and other health care organizations and institutions to maximize annual seasonal influenza immunization rates for all direct patient contact health care personnel without medical contraindications through all appropriate means. If other means are unsuccessful at maximizing immunization rates, then the MMS supports mandatory immunization programs. *(HP)*

MMS House of Delegates, 12/3/12
(substitute for 5/12/11 policy)
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society will promote access for seasonal influenza immunization for all populations identified by the Centers for Disease Control and Prevention. *(HP)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society will promote increased flu vaccination rates, and work to ensure access to flu vaccine for high-risk populations. *(D)*

The Massachusetts Medical Society will work to increase influenza vaccination rates among health care workers as recommended by the Advisory Committee on Immunization Practices. *(D)*

The Massachusetts Medical Society recommends that patients be provided with documentation of influenza vaccination for inclusion in their medical record, when the vaccination is provided by someone other than the patient's primary care provider. *(HP)*

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20
(Items 2, 5, and 6 of Original: Sunset MMS House of Delegates, 12/5/20)

The MMS opposes, to the degree legally permissible, nonmedical vaccine exemptions for all settings in which vaccines are required in Massachusetts. *(HP)*

The MMS will advocate for legislation and regulation that ends, to the degree legally permissible, nonmedical vaccine exemptions for all settings in which vaccines are required in Massachusetts. *(D)*

MMS House of Delegates, 5/4/19
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS recognizes the importance of in-person learning to the health, safety, education and development of school age children and there are significant health risks associated with school closures. *(HP)*

MMS House of Delegates, 5/8/21
(Auto-Sunset Items 1, 3, 4 of Original: Time-Limited Directive Completed MMs House of Delegates, 5/21/22)

Law Enforcement/Justice System
The MMS supports best practices, policies, procedures, and initiatives that maximize safe interaction with law enforcement in the Commonwealth. *(HP)*

The MMS supports the education of law enforcement officials that emphasizes how to deescalate potentially violent interactions. *(HP)*

The MMS acknowledges that violence that may occur during interactions with law enforcement is an important public health issue that disproportionately impacts marginalized populations. *(HP)*

MMS House of Delegates, 5/13/23

The MMS condemns the practice of universally shackling every patient who is involved with the justice system while they receive care in hospitals. *(HP)*

The MMS will advocate for the universal assessment of every individual who is involved with the justice system who presents for care, by medical and security staff in collaboration with correctional officers, to determine whether shackles are necessary or may be harmful, and, if restraint is deemed necessary, that the least restrictive alternative to shackling with metal cuffs is used when appropriate. *(D)*

The MMS will work with the AMA to advocate nationally for the end of universal shackling to protect human and patient rights, improve patient health outcomes, and reduce moral injury among physicians. *(D)*

MMS House of Delegates, 5/13/23

The MMS will develop policy and/or advocate for programs and legislation consistent with MMS tenets that support realigning police budgets with money to fund social service programs and re-investing directly in community resources. *(D)*

The MMS will advocate for alternative emergency responder models that use crisis workers with mental health and substance use training to respond to emergency calls. *(D)*

The MMS will advocate at the state level for limitation on the qualified immunity doctrine to promote accountability in law enforcement. *(D)*

The MMS acknowledges the public health implications of mass incarceration and supports efforts to meaningfully improve public health through decarceration and alternative interventions. *(HP)*

The MMS will develop policy and/or advocate for legislation, rules, or regulations that support investment in research evaluating the public health effects of police violence on individuals and on communities of color. *(D)*

MMS House of Delegates, 5/8/21

Marketing of Candy Containing Hemp Oil *(Please see Additional Policy under Prescription and Non-prescription Drugs)*
The MMS encourages the U.S. Food and Drug Administration to restrict the advertising of substances marketed in ways that could promote the use of illicit drugs among children. *(HP)*

MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Masks/Respiratory Pathogens
The Massachusetts Medical Society endorses the use of masks for all those wishing to reduce the risk of respiratory tract infection during the time of year when respiratory pathogens are most likely to circulate and whenever respiratory infections are known to be circulating when people are in close contact and indoors. *(HP)*

MMS House of Delegates, 5/8/21
(Item 2 of Original Auto-Sunset: Time-Limited Directive Completed MMS House of Delegates, 5/21/22)

Mouth Guards
The Massachusetts Medical Society (MMS) supports the use of mouth guards in all contact and collision sports, particularly in children and adolescents. *(HP)*

The MMS will develop educational materials encouraging the use of mouth guards in contact and collision sports for distribution to the public, including school, intramural, community, recreational, and club team coaches, via existing MMS communication channels. *(D)*

The MMS will encourage the Massachusetts Department of Public Health to include information on the benefits of mouth guard use in contact and collision sports on its Injury Prevention and Control Program web page. *(D)*

MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Non-Exercise Activity Thermogenesis (NEAT)
The MMS recognizes the health benefits of non-exercise activity thermogenesis (NEAT), in addition to regular physical activity and appropriate diet. *(HP)*

The MMS recommends that physicians educate themselves and their patients about non-exercise activity thermogenesis (NEAT), in order to promote health. *(HP)*

The MMS encourages non-exercise thermogenesis (NEAT) be incorporated as part of the work place environment. *(HP)*

MMS House of Delegates, 4/29/17

Obesity/Overweight/Weight Stigma
The MMS recognizes that comprehensive pediatric and adult obesity prevention, evaluation, and treatment requires frequent and regularly scheduled visits with a member of a primary or specialty care physician-led team which may include nurses, non-physician practitioners, registered dieticians, behavioral health specialists, certified health coaches, physical therapists, and social workers, among others, and that such visits may be conducted in person or utilize telemedicine. *(HP)*

The MMS will advocate for the expedient implementation of supportive payment and public health policies that cover comprehensive obesity prevention, evaluation, and treatment, including lifestyle and behavioral counseling, anti-obesity medications, and bariatric surgery, by members of physician-led obesity care teams and all physicians trained to provide this care, including those who care for the co-morbidities of obesity. *(D)*

The MMS will work with appropriate stakeholders, including specialty societies and MMS expert membership, to curate and post on the MMS website a list of evidence-based resources on the prevention, evaluation, and treatment of overweight and obesity for physicians desiring more education on this topic. *(D)*

The MMS will encourage Massachusetts medical schools and appropriate residency programs to include obesity prevention and treatment education in their curricula. *(D)*

MMS House of Delegates/ 5/13/23

The Massachusetts Medical Society recognizes that weight stigma in the health care setting leads to disparity of care and poorer health outcomes in patients with obesity. *(HP)*

The Massachusetts Medical Society will continue to provide and promote educational information to physicians and physicians in training about weight stigma. *(D)*

The MMS will advocate for legislative policies and institutional practices to prevent weight stigma. *(D)*

MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society will encourage the development of, and access to, physician-led, multidisciplinary weight management teams by advocating that third party payers cover evidence-based services, including behavioral, pharmacological, and surgical interventions, provided by these teams for patients with obesity. *(D)*

MMS House of Delegates, 12/1/12
Amended and Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society (MMS) recognizes overweight and obesity as serious health concerns for adults, adolescents, and children. *(HP)*

The MMS will work with managed care organizations and other third-party payors to better serve patients and to improve the quality, availability, and reimbursement for services aimed at preventing and treating overweight and obesity and associated comorbidities in all patients. *(D)*

The MMS promotes physician awareness of overweight and obesity and encourages physicians to take an active role in recognizing and addressing overweight and obesity and associated comorbidities in their patients. *(HP)*

The MMS promotes education about the health risks of overweight and obesity and the benefits of healthy lifestyle behaviors. *(HP)*

The MMS will continue to evaluate evidence for and support appropriate clinical, public health, and legislative measures to reduce and prevent the incidence of overweight and obesity through promotion of healthy lifestyles. *(HP)*

MMS House of Delegates, 5/12/06
MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed, MMS House of Delegates, 5/13/23

Oral Health

The MMS affirms that dental and oral health are integral components of basic health care and maintenance, regardless of age. *(HP)*

The MMS acknowledges the significance of highlighting the substantial contribution of dental and oral healthcare disparities to health inequity as well as to social and economic disparities. *(HP)*

The MMS will inform MMS members of existing American Medical Association and other resources regarding ongoing research, legislative actions, and administrative efforts to promote access to and adequate coverage by public and private payers for preventative and therapeutic dental services as integral parts of overall health maintenance to all populations. *(D)*

The MMS will work with other organizations to explore avenues to promote efforts to expand Medicare benefits to include preventative and therapeutic dental services without additional decreases in Medicare Part B Reimbursements. *(D)*

MMS House of Delegates, 12/9/23

The MMS recognizes oral health is an integral part of health and wellness. *(HP)*

The MMS will collaborate with and advocate to appropriate stakeholders for comprehensive integration of oral health services into all Accountable Care Organization models in Massachusetts. *(D)*

The MMS will support the development of oral health quality metrics for Accountable Care Organization models. *(D)*

MMS House of Delegates, 4/28/18

The Massachusetts Medical Society will advise physicians via existing communication venues, on common oral conditions, risk factors, and healthy behaviors as well as the medical, functional, emotional, and social consequences of poor oral health. *(D)*

The Massachusetts Medical Society will support efforts to make basic dental care accessible and affordable for all and available to homebound and nursing home patients as well as ambulatory patients. *(D)*

MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Organ Donation

The Massachusetts Medical Society (MMS) supports efforts to teach health professionals about the realities and benefits of tissue and organ donation, and how to communicate this information to their patients. *(HP)*

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

The MMS encourages the public to sign organ donor cards and inform their families of their wish to be organ donors. *(HP)*

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Pandemics

The MMS affirms its support for a data-driven pandemic policy approach which centers on equity. *(HP)*

The MMS affirms its support and will advocate to local, state and federal public health authorities for the following:

- indoor mask mandates and school mask mandates, when supported by public health data;
- increased state and federal funding for improved ventilation in schools and other public spaces;
- distribution of high-quality masks in Massachusetts communities most-impacted by COVID and other respiratory illnesses to prevent community spread;
- more equitable access to testing and antiviral treatments. (*HP)/(D)*

MMS House of Delegates, 5/21/22

Performance Enhancing Drugs

The Massachusetts Medical Society calls upon its members and all physicians to oppose the use of performance enhancing drugs for the purpose of trying to improve athletic performance or for any purpose other than that which is medically indicated. *(HP)*

MMS Council, 5/10/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13

Physical Activity
The MMS recognizes the health benefits of daily physical activity and the health risks of sedentary behavior. *(HP)*

The MMS supports the recommendations of the US Department of Health and Human Services *Physical Activity Guidelines* for adults and children, for regular moderate or vigorous intensity physical activity and strengthening exercise, including those with disabilities or chronic conditions as their age, abilities, and conditions allow. *(HP)*

The MMS will advocate for policies and programs that make available regular, safe, physical activity for children and adults including those with disabilities, older adults and those with socioeconomic barriers to activity. *(D)*

MMS House of Delegates, 5/4/19

Physical Activity/For Students
The MMS recognizes physical activity in adults and children as important to maintaining good health and promote opportunities for physical activity for adults and children. *(HP)*

MMS House of Delegates, 5/12/06
MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

The Massachusetts Medical Society support legislation to require all public and private schools in the Commonwealth to provide a minimum of 30 minutes of physical activity per day at the elementary school level and a minimum of 45 minutes of physical activity per day at the middle and high school levels. *(D)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Pre-Hospital Stroke Protocol
The MMS supports efforts to encourage early recognition of signs and symptoms of stroke and activation of the 911 emergency system, in order to promote early diagnosis and treatment of stroke. *(D)*

MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Public Safety
The Massachusetts Medical Society is opposed to statutory penalties on health care professionals who are protecting the interests of patients with regard to the allocation or rationing of limited medical resources. *(HP)*

MMS House of Delegates, 05/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Public Transportation
That the MMS supports improved safety and continued upkeep of public transportation systems and surrounding infrastructure. (HP)

MMS House of Delegates, 5/13/23

Racism
The Massachusetts Medical Society recognizes that racism is a public health crisis. *(HP)*

The Massachusetts Medical Society acknowledges that racism is pervasive in all sectors and industries, including health care, and has detrimental effects on MMS members and the public in Massachusetts. *(HP)*

The Massachusetts Medical Society acknowledges racism is a social determinant of health and is a root cause of health inequities and negative health outcomes including illness and premature death. *(HP)*

The Massachusetts Medical Society is committed to being an antiracist organization and will work to promote equity and racial justice by prioritizing antiracism in its policies, strategic plan, governance, and activities. *(HP)*

MMS House of Delegates, 12/5/20

The MMS affirms that racial inequities in income and wealth are a pressing public health problem. *(HP)*

The MMS will advocate for policies at the state and national levels that aim to simultaneously reduce racial wealth and income inequality and health disparities. *(D)*

The MMS will advocate for funding for research on the most effective means by which to achieve racial health equity. *(D)*

The MMS will collate and report annually on its advocacy that promotes equity and anti-racism. *(D)*

MMS House of Delegates, 12/5/20

Social Determinants of Health (*Please Also See Policies Under Food Insecurity Screening and Strategic Direction)*
The Massachusetts Medical Society acknowledges that social determinants of health play a key role in health outcomes and health disparities, and that addressing the social determinants of health for patients and communities is critical to the health of our patients, our communities, and a sustainable, effective health care system. *(HP)*

The Massachusetts Medical Society will, as appropriate, advocate for policies aimed at improving social determinants of health for all people. *(D)*

The Massachusetts Medical Society will work with physicians, health systems, and payers to develop sustainable care delivery and payment models that incorporate innovative and creative ways of improving the social determinants of health for all patients. *(HP)*

The Massachusetts Medical Society will educate its members about social determinants of health and the importance of addressing social determinants of health in order to improve health outcomes and promote health equity.
(D)

MMS House of Delegates, 12/1/18

State Funding for Disease Control Programs
The Massachusetts Medical Society (MMS) will support funding by the Commonwealth of Massachusetts for public health efforts to reduce the incidence of tuberculosis (TB) through surveillance, education, and clinical services. *(D)*

The MMS will advocate for the maintenance of adequate funding levels for the Massachusetts Tobacco Control Program and other public health programs for disease control and prevention administered by the Commonwealth of Massachusetts Department of Health. *(D)*

MMS House of Delegates, 5/31/02
Amended and Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Standard Time/Daylight Savings Time
The MMS will advocate at the state and federal level for legislation and to the AMA to support permanent Standard Time and against legislation supporting seasonal clock change or permanent Daylight Saving Time. *(D)*

MMS House of Delegates, 5/21/22

State Laboratory
The Massachusetts Medical Society will advocate for appropriate state funding of the Hinton State Laboratory in order to successfully maintain existing responsibilities and manage ongoing and increasing needs for infrastructure, facilities, personnel, and services. *(D)*

MMS House of Delegates, 12/7/13
Reaffirmed MMS House of Delegates, 12/5/20

Well Water
The MMS supports equity in the regulatory protection of safety of drinking water from private wells that is at least comparable to that required of public water systems. *(HP)*

The MMS will support legislation that addresses the lack of private well water safety regulations. *(D)*

MMS House of Delegates, 5/13/23

PUBLIC RELATIONS

High School Doctor for a Day Program
The Massachusetts Medical Society's (MMS) District Leadership Council will explore the merits of creating a statewide High School Doctor for a Day Program to be jointly sponsored by the MMS and the district medical societies through the Society's three regional offices. *(D)*

The MMS, through the District Leadership Council, will continue to assist in the financial support of district-based programs (such as the High School Doctor for a Day Program) via Grants-in-Aid, while allowing the districts to select dates and venues that are reasonable for the specific districts. *(D)*

The MMS's regional offices will be available to work with interested district medical societies to plan a High School Doctor for a Day Program. *(D)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Physician Role
The Massachusetts Medical Society shall incorporate information into existing and ongoing communications activities about the education, skills, and role of physicians in providing comprehensive patient care, including the scope of physician activities beyond the patient encounter, such as record keeping, consultation with colleagues, continuing medical education, and other efforts required to deliver optimal patient care in the current environment. *(D)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 12/5/20

REPRODUCTIVE HEALTH *(Please See Additional Policies Under Violence)*

Contraception *(Please See Additional Policies Under Abortion, Abortion and Contraception)*
The MMS supports state agencies' public awareness campaigns about Massachusetts' requirements (A) that patients receive coverage for FDA-approved contraceptive drugs and other products without cost sharing and (B) that a patient continuing on a prescription contraceptive may fill up a 12-month supply of their prescription at one time (currently known as the "ACCESS Law"). Specifically:

- About the no cost coverage of contraceptive drugs, devices, or products for all persons covered by state-funded health care plans, all commercial-funded health care plans, and insurance plans under the Group Insurance Commission that are not exempt under the current law; and

- About pharmacies being required to dispense a one-year supply of contraceptive drugs and if requested by a member of a state-funded or commercially funded health care plan or a plan under the Group Insurance Commission and that if the covered drug is deemed medically inadvisable by the covered persons' physician, the insurer will provide coverage for an alternate prescribed contraceptive. *(HP)*

That the MMS will continue to publicize through existing print/web channels resources for its members to learn more about current Massachusetts law in relation to coverage for contraceptive drug and devices; the ability of physicians to prescribe contraceptive drugs, devices, or products for a 12-month period; and the ability to advocate for their patients when pharmacies and insurers deny coverage. *(D)*

MMS House of Delegates, 12/4/21
(Item 2 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/10/22)

The MMS will work with all relevant stakeholders to ensure that all Massachusetts health insurance policies provide coverage for both long-acting reversible contraceptives devices and the insertion procedure in the immediate postpartum period. *(D)*

MMS House of Delegates, 12/2/17

The MMS advocates for hospitals and health care facilities to educate survivors of sexual assault about emergency contraception (EC) as well as to provide EC if the survivor so chooses. *(HP)*

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/8/09
(Items 1 and 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed 5/13/23

The Massachusetts Medical Society (MMS) supports policy adapted from the American Medical Association: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of contraceptive counseling; and (2) to enhance efforts to expand access to emergency contraception without cost-sharing, including making emergency contraception pills more broadly available including, but not limited through, hospitals, clinics, emergency rooms, acute care centers, pharmacies (over-the-counter and available without cost-sharing through a statewide standing order), and physicians and other clinicians' offices. *(HP)*

The MMS supports providing emergency contraceptive medication to patients on an over-the-counter basis. *(HP)*

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS requests all payers of health services including Medicaid, Medicare, and all health insurers and health plans to include coverage of contraceptives, including emergency contraceptives, without cost-sharing in their pharmacy benefits programs. *(D)*

The MMS supports requiring insurers to reimburse contraceptive medication refills consistent with Massachusetts law, including coverage for a single-dispensing of a prescription for contraceptive drugs, devices, or products for a 12-month period to promote continuous access for patients. *(HP)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
(Item 2 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/2/15
(Amended and Reaffirmed MMS House of Delegates, 5/21/22)

The MMS supports legislative and regulatory efforts to provide emergency contraception directly to female patients of child bearing age in a medically sound and safe manner. *(HP)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Item 3 of Original: Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Items 1 and 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/4/19

COVID-19 Vaccine/Vaccines Safety

The MMS advocates for appropriate inclusion of individuals who are pregnant, breastfeeding, or planning to become pregnant in premarketing vaccine trials in collaboration with state and federal agencies that oversee vaccine safety and other state and national medical societies. *(HP)*

MMS House of Delegates, 12/4/21
(Item 1 of Original Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/10/22)

Substance Use *(Please See Additional Policy under Prescription and Non-prescription Drugs)*
The Massachusetts Medical Society recognizes the autonomy of all patients, including pregnant women, and strongly opposes interference in clinical decision making when a woman is found to have used or is using unauthorized or therapeutically prescribed narcotics during pregnancy. *(HP)*

The MMS recognizes that pregnant women with substance use disorders require diagnosis and treatment for the benefit of mother and fetus: primary prevention strategies for all persons at risk for substance use disorders should be part of the overall strategy. The MMS opposes the criminalization of substance use on the basis of pregnancy, including via the misuse of existing child endangerment or child abuse laws that were not intended for this purpose. *(HP)*

MMS House of Delegates, 12/6/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Fertility Services/Preservation
The MMS is committed to improving access to fertility services for all patients, regardless of income level, race/ethnicity, sexual orientation, gender identity, or marital status. *(HP)*

The MMS supports expanding the definition of "infertility" used in mandated insurance coverage for fertility services/infertility treatment to include coverage for unpartnered individuals and those in partnerships without the biological ability to reproduce. *(HP)*

The MMS will advocate at the state level for legislation to expand the state's definition of "infertility" for purposes of mandated coverage for fertility services to include a person's inability to reproduce either as a single individual or with a partner without medical intervention or a licensed physician's findings based on a patient's medical, sexual, and reproductive history, age, physical findings, or diagnostic testing. *(D)*

MMS House of Delegates, 5/13/23

The MMS supports educational initiatives that provide information about fertility preservation for undergraduate and graduate medical trainees and physicians. *(HP)*

The MMS supports access to and insurance coverage for undergraduate and graduate medical trainees and physicians to fertility preservation. *(HP)*

MMS House of Delegates, 12/10/22

The MMS supports the adoption of legislation designed to require insurance coverage of fertility-preservation services. *(D)*

The MMS will advocate that all surgical and medical treatments that are intended to preserve the fertility potential of patients with cancer or premature gonadal failure after gonadotoxic therapy be considered essential services, and not elective procedures that would be prohibited during a pandemic or public health crisis, according to current state guidelines. Patients with cancer or undergoing treatment that will cause gonadal failure should not delay initiation of their fertility preservation services because a delay will close their window of opportunity to preserve gametes and embryos prior to starting cancer treatment or worsen their cancer prognosis or both. *(D)*

MMS House of Delegates, 12/5/20

The MMS will continue to support the current state mandate for expansion of coverage to include infertility treatments for members covered under plans that include pregnancy-related benefits to the same extent benefits are provided for other pregnancy-related procedures. *(HP)*

MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/8/21

Hypertensive Disorders of Pregnancy
The MMS will collaborate with relevant stakeholders to advocate for mitigation of sociodemographic disparities in care for pregnant people. *(D)*

The MMS supports innovative systems and policies that address challenges around the provision of pregnancy-related care in rural areas, particularly care of complex pregnancy conditions. *(HP)*

MMS House of Delegates, 5/13/23

Menstrual Products
The MMS supports efforts to increase access to free menstrual products within schools, correctional institutions, and shelters. *(HP)*

MMS House of Delegates, 12/10/22
(Item 2 of Original: Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/9/23)

Mental Health Services: Gestation and Postpartum
The MMS recognizes that there are inadequate resources to treat postpartum mood disorders across the Commonwealth. *(HP)*

The MMS is committed to improving access to evidence-based screening, diagnosis, and treatment of postpartum mood disorders. *(HP)*

MMS House of Delegates, 5/13/23

The MMS supports legislation that mandates insurance coverage for screening for postpartum depression. *(HP)*

The MMS is committed to universal screening for postpartum mood disorder. *(HP)*

The MMS is committed to improved, timely access to behavioral health services, including for peripartum mood disorders. *(HP)*

The MMS will be an advocate for adequate insurance reimbursement and network adequacy for behavioral health services. *(HP)*

MMS House of Delegates, 5/13/23

The MMS supports a culture of awareness, destigmatization, screening, referral, and treatment for psychiatric illnesses during pregnancy and postpartum to ensure that patients have access to effective and affordable mental health services. *(HP)*

The MMS will advocate for expanding health insurance coverage and reimbursement of medically necessary mental health services during pregnancy and postpartum. *(D)*

The MMS will work with other appropriate organizations and specialty societies to support and promote awareness among patients, families, and providers of the risks of mental illness during pregnancy and postpartum. *(D)*

The MMS will work with all appropriate parties such as insurers, health care systems, providers, consumers, allied health care professionals, and the government to foster integration of mental health care with general medical care. *(D)*

MMS House of Delegates, 12/3/11
Items 1-3 of Original Amended and Reaffirmed MMS House of Delegates, 4/28/18
Reaffirmed MMS House of Delegates, 5/4/19

Mifepristone
The Massachusetts Medical Society will join other professional organizations in affirming that the Risk Evaluation and Mitigation Strategy (REMS) classification on mifepristone is not evidence-based. (*HP*)

The Massachusetts Medical Society will engage in advocacy to re-evaluate the current REMS classification on mifepristone to reduce barriers and improve access to reproductive health care. (*D*)

The Massachusetts Medical Society will encourage the dissemination of education for physicians and other health care professionals on the use of mifepristone in the management of early pregnancy loss. (*D*)

MMS House of Delegates, 5/4/19

Nonviable Pregnancy
The MMS supports patients' timely access to standard of care treatment of nonviable pregnancy in both emergent and non-emergent circumstances. *(HP)*

The MMS opposes any hospital directive or regulations that may hinder patients' timely access to the accepted standard of care in both emergent and non-emergent cases of nonviable pregnancy. *(HP)*

MMS House of Delegates, 12/4/21

Obstetrical Care in Underserved Areas
The MMS supports legislation and regulation for increased access to obstetric care in rural areas. *(HP)*

The MMS supports legislation and regulation for improved and timely access to patients' medical records. *(HP)*

The MMS supports legislation and regulation providing insurance coverage for out-of-network care for patients who must travel due to limited local networks. *(HP)*

MMS House of Delegates, 12/9/23

Racial and Ethnic Disparities in Maternal and Infant Health Outcomes
The MMS recognizes that racial and ethnic disparities in maternal mortality, severe maternal morbidity, and infant mortality are inextricably tied to racism. *(HP)*

The MMS is committed to improving health equity by eliminating racial and ethnic disparities in maternal and infant health outcomes. *(HP)*

The MMS will advocate for legislative and regulatory policies that improve maternal and infant health outcomes and promote health equity by eliminating racial and ethnic disparities in maternal and infant health outcomes for all birthing individuals and families of color. *(D)*

MMS House of Delegates, 12/4/21

QUALITY OF CARE

Patient-Reported Outcome Measures

MMS Principles on Patient-Reported Outcome Measures (PROMs)

Quality improvement activities are an integral part of health care delivery today.

PROMs are expected to play a more prominent role in improving and assessing performance by including the patient's assessment of the comparative effectiveness of different treatments, in part because of the growing emphasis on patient-centered care and value-based payment designs.

In the era of patient-centered care and motivation toward high-quality care, active implementation of patient-reported outcome tools (Internet, automated phone systems, phone app, etc.) is a logical next step toward achieving these goals, as long as those tools are accessible to those less comfortable with technology and account for the cost of implementation.

Implemented correctly, PROMs have the potential to improve patient-physician communication, increase symptom management and control, and increase patient and physician satisfaction.

When selecting a PRO to measure, the PROM should be short, relevant to clinical care, validated, industry-standard, and may be covered by PROMIS (Patient-Reported Outcomes Measurement Information System) domain.

Routinization of this type of two-way communication between the provider and the patient, through use of the electronic tools mentioned above, may serve to improve care in ways that advance the Triple Aim's design to (i) improve patient experience, (ii) enhance the health of populations, and (iii) reduce per capita cost of health care.

Health plans, payers, and other health care improvement organizations should reimburse for quality improvement implementation activities, especially PROMs, as these measures require technology support, workflow adjustments, and continuous improvement.

However, PROMs should not be used to benchmark the performance of providers in different practices, specialties, or geographic locations against one another, potentially influencing payers to link reimbursement to evidence of the effectiveness of their treatment. Instead, these quality improvement tools should be used to advance quality of care within a specific practice or medical center, improve provider-patient communication, and enhance understanding of expectations. Because PROMs are in their infancy, more research needs to be done to understand how to risk-adjust these measures and how to account for realistic and unrealistic patient and provider expectations.

In addition to the need for added research on risk adjustment and patient expectations, PROMs performance results should not be linked to reimbursement due to many other factors, including patients' compliance, demographic, and social factors, which influence outcomes and create bias. Because PROMs results are not completely attributable to the physician's performance alone, providers find it hard to reconcile reimbursement and the often-imprecise nature of PROMs results. Rather, PROMs should be used to complement quality improvement activities.

The need for demographic (age, sex, etc.) risk adjustment to make PROMs more valuable should be emphasized both at the clinical level for providers to be able to use PROMs appropriately but even more so at the health plan level if PROMs are to be used for any type of provider comparison or payment.

Although the goal of medicine is to improve health outcomes for patients, using PROMs results for physician accountability and reimbursement requires additional research and validation of measures and outcomes.

The MMS strongly advocates for monitoring national dialogue surrounding PROMs, including a focus on their validity and usefulness in clinical practice.

The MMS will keep the membership informed of identified issues with relevant implemented patient-reported outcome measures and advocate strongly, by whatever means appropriate, for the growth and maturation of PROMs as a quality improvement tool and against implementation of inappropriate or inadequate PROMs, and against the use of PROMs results for quality incentive payments. *(HP)*

MMS House of Delegates, 4/28/18

Patient Safety

The Massachusetts Medical Society accepts the Institute of Medicine's (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report *Priority Areas for National Action, Transforming Health Care Quality* (2003):

1. That the priority areas collectively:
    - Represent the U.S. population's health care needs across the lifespan, in multiple health care settings involving many types of health care professionals.
    - Extend across the full spectrum of health care, from keeping people well and maximizing overall health; to providing treatment to cure people of disease and health problems as often as possible; to assisting people who become chronically ill to live longer, more productive, and comfortable lives; to providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.

2. Use of the following criteria for identifying priority areas:
    - Impact – the extent of the burden – disability, mortality, and economic costs – imposed by a condition, including effects on patients, families, communities, and societies.
    - Improvability – the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
    - Inclusiveness – the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/race (equity); the generalizability of associated quality improvement

strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach).

3. That DHHS, along with other public and private entities, focus on the following areas for transforming health care:
   - Care coordination (cross-cutting)
   - Self-management/health literacy (cross-cutting)
   - Asthma – appropriate treatment for persons with mild/moderate persistent asthma
   - Cancer screening that is evidence-based – focus on colorectal and cervical cancer
   - Children with special health care needs
   - Diabetes – focus on appropriate management of early disease
   - End of life with advanced organ system failure – focus on congestive heart failure and chronic obstructive pulmonary disease
   - Frailty associated with old age – preventing falls and pressure ulcers, maximizing functions, and developing advanced care plans
   - Hypertension – focus on appropriate management of early disease
   - Immunization – children and adults
   - Ischemic heart disease – prevention, reduction of recurring events, and optimization of functional capacity
   - Major depression – screening and treatment
   - Medication management – preventing medication errors and overuse of antibiotics
   - Nosocomial infections – prevention and surveillance
   - Pain control in advanced cancer
   - Pregnancy and childbirth – appropriate prenatal and intrapartum care
   - Severe and persistent mental illness – focus on treatment in the public sector
   - Stroke – early intervention and rehabilitation
   - Tobacco dependence treatment in adults
   - Obesity (emerging area)

4. That the Agency for Healthcare Research and Quality (AHRQ), in collaboration with other private and public organizations, be responsible for continuous assessment of progress and updating of the list of priority areas. These responsibilities should include:
   - Developing and improving data collection and measurement systems for assessing the effectiveness of quality improvement efforts.
   - Supporting the development and dissemination of valid, standardized measures of quality.
   - Measuring key attributes and outcomes and making this information available to the public.
   - Revising the selection criteria and the list of priority areas.
   - Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.
   - Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.
   - Disseminating the results of strategies for quality improvement in the priority areas.

5. That data collection in the priority areas:
   - Go beyond the usual reliance on disease – and procedure-based information – to include data on the health and functioning of the U.S. population.
   - Cover relevant demographic and regional groups, as well as the population as a whole, with particular emphasis on identifying disparities in care.
   - Be consistent within and across categories to ensure accurate assessment and comparison of quality enhancement efforts.

6. That the Congress and the Administration provide the necessary support for ongoing process of monitoring progress in the priority areas and updating the list of areas. This support should encompass:
   - The administrative costs borne by the AHRQ.
   - The costs of developing and implementing data collection mechanisms and improving the capacity to measure results.

- The costs of investing strategically in research aimed at developing new evidence on interventions that improve the quality of care and at creating additional, accurate, valid, and reliable measures of quality. Such research is especially critical in areas of high importance in which either the scientific evidence for effective interventions is lacking or current measures of quality are inadequate.

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) accepts the Institute of Medicine's (IOM) thirteen recommendations in their report, "Crossing the Quality Chasm," with an amendment to recommendation three:

Recommendation 1: All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.

Recommendation 2: All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable.

Recommendation 3: Congress should continue to authorize and appropriate funds for, and the Department of Health and Human Services should move forward expeditiously with the establishment of, monitoring and tracking processes for use in evaluating the progress of the health system in pursuit of the above-cited aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Efforts should be made to eliminate any duplication of reporting or monitoring processes of care. The Secretary of the Department of Health and Human Services should report annually to Congress and the President on the quality of care provided to the American people.

Recommendation 4: Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

· Care based on continuous healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

· Customization based on patient needs and values. The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

· The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

· Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.

· Evidence-based decision making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.

· Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.

· The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical

practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.

· Anticipation of needs. The health system should anticipate patient needs, rather than simply react to events.

· Continuous decrease in waste. The health system should not waste resources or patient time.

- Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Recommendation 5: The Agency for Healthcare Research and Quality should identify not fewer than 15 priority conditions, taking into account frequency of occurrence, health burden, and resource use. In collaboration with the National Quality Forum, the Agency should convene stakeholders, including purchasers, consumers, health care organizations, professional groups, and others, to develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years for each of the priority conditions.

Recommendation 6: Congress should establish a Health Care Quality Innovation Fund to support projects targeted at (1) achieving the six aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity; and/or (2) producing substantial improvements in quality for the priority conditions. The Fund's resources should be invested in projects that will produce a public-domain portfolio of programs, tools, and technologies of widespread applicability.

Recommendation 7: The Agency for Healthcare Research and Quality and private foundations should convene a series of workshops involving representatives from health care and other industries and the research community to identify, adapt, and implement state-of-the-art approaches to addressing the following challenges:

- Redesign of care processes based on best practices
- Use of information technologies to improve access to clinical information and support clinical decision making
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, and settings over time
- Incorporation of performance and outcome measurements for improvement and accountability

Recommendation 8: The Secretary of the Department of Health and Human Services should be given the responsibility and necessary resources to establish and maintain a comprehensive program aimed at making scientific evidence more useful and accessible to clinicians and patients. In developing this program, the Secretary should work with federal agencies and in collaboration with professional and health care associations, the academic and research communities, and the National Quality Forum and other organizations involved in quality measurement and accountability.

Recommendation 9: Congress, the executive branch, leaders of health care organizations, public and private purchasers, and health informatics associations and vendors should make a renewed national commitment to building an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education. This commitment should lead to the elimination of most handwritten clinical data by the end of the decade.

Recommendation 10: Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement.

Recommendation 11: The Health Care Financing Administration [CMS] and the Agency for Healthcare Research and Quality, with input from private payers, health care organizations, and clinicians, should develop a research agenda to identify, pilot-test, and evaluate various options for better aligning current payment methods with quality improvement goals.

Recommendation 12: A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for (1) restructuring clinical education to be consistent with the principles of the 21st-century health system throughout the continuum of undergraduate, graduate, and continuing education for medical, nursing, and other professional training programs; and (2) assessing the implications of these changes for provider credentialing programs, funding, and sponsorship of education programs for health professionals.

Recommendation 13: The Agency for Healthcare Research and Quality should fund research to evaluate how the current regulatory and legal systems (1) facilitate or inhibit the changes needed for the 21st-century health care delivery system, and (2) can be modified to support health care professionals and organizations that seek to accomplish the six aims set forth in Chapter 2:

- Safe — avoiding injuries to patients from the care that is intended to help them.

- Effective — providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centered — providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely — reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient — avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable — providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The MMS adds the following additional recommendations to the IOM recommendations:

1) Changes introduced into the health care system must honor patient confidentiality and privacy.
2) Physicians by the nature of their training and their responsibilities have a unique perspective on the health care system and their input is vital to any change. In addition, while physicians respect and value other health care professionals who work in the health care system, a broad array of physicians should be consulted when structural changes in the health care system are suggested.

(HP)

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/13/23

The MMS will advocate for patient safety initiatives to be incorporated into the development of guidelines and protocols. *(D)*

The MMS will continue to take a leadership role in promoting patient safety initiatives, including education, and dissemination of appropriate patient safety information to members. *(D)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 1, 2, 5, and 6 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/8/21

Quality Measurement/Quality Improvement

The MMS will keep the membership informed of identified issues with relevant implemented quality measures and advocate strongly, by whatever means appropriate to the situation, against implementation of inappropriate or inadequate quality measures. *(D)*

MMS House of Delegates, 12/7/13
(Item 1 of 2 Auto-Sunset: Time-Limited Directive Completed, MMS House of Delegates, 12/6/14)
Reaffirmed MMS House of Delegates, 5/21/22

The MMS will advocate through legislative or regulatory means to require that commercial medical insurers select from a standard set of quality measures to evaluate physician quality compliance. This measure would be used for financial incentive and tiering programs. *(D)*

MMS House of Delegates, 5/19/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society (MMS) will continue to participate in the Massachusetts Health Quality Partners (MHQP) and that MMS representatives will communicate appropriate information and recommendations to relevant committees and leadership. *(D)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society adopts the following principles, for quality of medical care initiatives that the Society should undertake or embrace:

I. Definition of Quality

   A. Institute of Medicine: "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"
   B. Physicians' perspective as patient advocates (in contrast with those of health plans, purchasers) focuses on appropriate clinical decision-making (related to knowledge and judgment), evidence-based medicine, patient experience, and performance skills

II. Individual Physician Responsibility for Quality Management
   A. There are professional privileges granted from society to physicians. In return, physicians have a professional responsibility to understand and apply scientific and technical knowledge for the benefit of patients (i.e., quality medical care)
   B. Physicians' claims to the public trust are derived from our unique role as patient advocates

III. Responsibilities of the Massachusetts Medical Society (MMS)

   A. Our mission states: "The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit, and welfare of the citizens of the Commonwealth"
   B. MMS is the primary "grassroots" organization representing Massachusetts physicians
   C. Our own past history demonstrates concern for quality in areas such as continuing medical education (CME), advancement of medical knowledge through the ownership of *The New England Journal of Medicine* and NEJM Group, and participation in guideline promulgation and implementation
   D. MMS has broad experience and readily available expertise in patient care, research, and education

IV. Many policy decisions regarding medical practice (e.g., legislative and regulatory) are at the state level. Therefore, a state medical society is the most appropriate arena for many policy decisions.

V. Role of American Medical Association

   A. Promote physician involvement in continuous quality improvement (CQI): data collection, analyses, and feedback loops
   B. Promote standards for physician profiling
   C. Promote effective quality improvement models
   D. Encourage development and provision of educational and training opportunities to improve patient care
   E. Encourage outcomes research
   F. Evaluate quality assurance programs
   G. Advocate nationally for quality in medicine
   H. Promotes the art and science of medicine and the betterment of public health

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 5/4/19

Quality of Medical Care Initiatives, which the Massachusetts Medical Society undertakes consistent with the MMS strategic plan to keep in mind fiscal realities at the time, should have the following characteristics:

I. Quality Measures from Physicians' Perspective: i.e., Appropriate Clinical Decision-Making, Evidence-Based Medicine, Patient Experience, Performance Skills, and Desired Outcomes
II. Medical Services Ranging from Those Performed for Individual Patients to Those Performed for the Public Health
III. Categories of physicians as participants in quality initiatives
   A. Geographic Area
   B. Specialty
   C. Impaired
   D. Outlier Practice Patterns

E. Other Groups

IV. Conceptual Frameworks for Quality Initiatives

A. Measurement: Profiling

(1)System Focus

a) Structures: (e.g. credentialing, liability)

b) Processes: (e.g. compliance to guidelines)

c) Outcomes: (e.g. mortality, quality of life)

(2)Role of Massachusetts Medical Society

a) Set standards for agencies to measure through the development of a set of attributes or criteria by an expert clinical panel

b) Direct role in the profiling of physicians

B. Substantive Medical Management: Knowledge Base, Judgment, Decision-Making

(1)Curricula

a) Directly providing and organizing CME and Non-CME courses

b) Accrediting Other Physician-Affiliated Organizations

c) Implementing Scientific Advances in Physicians' Clinical Practices

(2)Mentoring

(3)Clinical Practice Guidelines: Refine, approve, implement, evaluate

(4)Other systems of support

V. Physicians Partnering with Patients, along with other Providers: Academic Consortia, Hospitals, and other Professional Organizations

VI. Establishment of a Quality of Medical Care Program

VII. Clarity of Design and Focus of the Quality of Medical Care Program

A. Substantive content of medical program

B. Program target population

C. Definition of program outcomes

D. Definition of program time-line

E. Program evaluation component

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Amended and Reaffirmed House of Delegates, 5/4/19

Sleep Medicine

The MMS supports continued delivery of high-quality care for patients with sleep disorders in Massachusetts. *(HP)*

The MMS supports incorporation of new diagnostic tools and therapies to treat sleep disorders utilizing evidence-based clinical guidelines and accreditation standards. *(HP)*

The MMS support the principle that management of chronic sleep disorders requires programs that incorporate comprehensive sleep evaluations, access to appropriate testing, evidence-based treatment protocols, and collaboration between primary care providers and sleep specialists. *(HP)*

MMS House of Delegates, 12/4/10
Reaffirmed MMS House of Delegates, 4/29/17

REGULATION AND LICENSURE

Board of Registration in Medicine (BORIM)

The MMS supports the disclosure on a physician's Board of Registration in Medicine (BORIM) or National Practitioner Data Bank (NPDB) profile of disciplinary actions, pleas, admissions, or findings of guilt or liability only when determinations are finalized and adverse to the physician. *(HP)*

The MMS will advocate for rescission from a physician's BORIM and/or NPDB profile of all information pertaining to disciplinary actions that have been fully reversed/annulled/rescinded/voided by the originating entity. *(D)*

The MMS will advocate that any BORIM discipline that results from the BORIM scrutiny initiated from original allegations that have since been found in favor of the physician must be a stand-alone discipline that does not include any reference to the original allegations or subsequent event that stemmed from the original allegations. *(D)*

The MMS will advocate for BORIM to create a narrative section for physicians to make a statement under any and all allegations that are posted to a physician's BORIM profile in order that both parties have equal presence to the matter on the profile. *(D)*

MMS House of Delegates, 12/7/19

The Massachusetts Medical Society (MMS) reaffirms its support for adequate funding for the Board of Registration in Medicine. *(HP)*

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society will work with the Board of Registration in Medicine to establish limitations for accessing physicians' medical and/or mental health treatment records when they are irrelevant to the matter under investigation. *(D)*

The Massachusetts Medical Society will encourage the Board of Registration in Medicine, when it is inquiring into the medical or mental health status of a licensee, to accept a treatment summary provided by the treating physician in lieu of accessing the licensee's medical or mental health records. *(D)*

If negotiations with the Board of Registration in Medicine do not result in a satisfactory response, the Massachusetts Medical Society's Committee on Legislation will seek to secure a statutory privilege protecting physicians' medical and/or mental health treatment records from access by the Board of Registration in Medicine, except and to the degree that the Board can establish a compelling need to access those portions relevant to a current investigation. *(D)*

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

BORIM and Volunteer Licenses

The Massachusetts Medical Society upholds the Massachusetts Board of Registration in Medicine as the only licensing authority in Massachusetts for physicians. The Massachusetts Medical Society condemns programs which deselect, prohibit or obstruct licensed physicians, in good standing in Massachusetts, from providing patient care. *(HP)*

MMS House of Delegates, 11/19/94
Reaffirmed MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

The MMS will advocate for the Massachusetts Board of Registration in Medicine (BORIM) to eliminate the fee for a volunteer license to practice medicine. *(D)*

The MMS will advocate for the removal of the requirement that the BORIM approve work sites for physicians with volunteer licenses. *(D)*

MMS House of Delegates, 4/28/18

Centralized Verification
The Massachusetts Medical Society supports the principle that regulation or licensure by any body other than the Board of Medicine is extraneous, redundant, and will add to the cost of medical services, and that the MMS should act appropriately to repeal any legislation that would require regulation or licensure of physicians by any other regulatory body. *(HP)*

MMS Council, 10/14/81
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Clinical Skills Assessment
The Massachusetts Medical Society strongly opposes the implementation of a routine clinical skills assessment examination as a part of the physician relicensure process, unless validated specialty-specific criteria are established and unless such an examination has been shown to provide a health benefit to the citizens of the Commonwealth. *(HP)*

MMS House of Delegates, 11/04/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

International Medical Graduates: GME Training/Licensure
The MMS will advocate at the federal and/or state level for a program that waives the two-year residence requirement following completion of a J1 exchange visa for physicians. *(D)*

MMS House of Delegates, 12/1/18

The Massachusetts Medical Society supports a decrease in the number of years of American Osteopathic Association (AOA)/Accreditation Council for Graduate Medical Education (ACGME) approved GME training required for international medical graduates (IMGs) to achieve parity with U.S. medical graduates (USMGs) in order to obtain medical licensure. *(HP)*

The Massachusetts Medical Society will aggressively advocate for a decrease in the number of years of AOA/ACGME approved GME training required for IMGS to achieve parity with USMGs in order to obtain medical licensure. *(D)*

MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

Maintenance of Certification & Licensure
The MMS acknowledges that the requirements within the Maintenance of Certification process are costly and time intensive, and they result in significant disruptions to the availability of physicians for patient care. *(HP)*

The MMS acknowledges that after initial specialty board certification, the MMS affirms the professionalism of the physician to pursue the best means and methods for maintenance and development of their knowledge and skills. *(HP)*

The MMS reaffirms the value of continuing medical education, while opposing mandatory Maintenance of Certification as a requirement for licensure, hospital privileges, and reimbursement from third party payers. (HP)

The MMS will communicate our position regarding Maintenance of Certification to the AMA, specialty societies, universities, and physician and industry groups involved with independent continuing medical, clinical, and scientific education.

(D/HP) MMS House of Delegates, 12/6/14
Reaffirmed MMS House of Delegates, 5/8/21

The Massachusetts Medical Society adopts the following principles.

Proposed Massachusetts Medical Society Principles on Maintenance of Licensure (MOL):

The Massachusetts Medical Society supports continuous lifelong learning by physicians and quality improvement in the practice of medicine; and will only support implementation of MOL requirements when substantial and convincing evidence demonstrates that such requirements will improve clinical outcomes/patient care and that the clinical benefit of these additional requirements will significantly outweigh the costs (both direct and indirect) to physicians and to society

— i.e., patient access — that are associated with any additional requirements beyond those currently required for renewal of medical licenses.

That in the event that substantial and convincing evidence exists and the Massachusetts Board of Registration moves forward with implementation of Maintenance of Licensure (MOL), the Massachusetts Medical Society will support the following:

a. Any MOL activity should be integrated, wherever feasible, into the existing infrastructure of the health care environment. For example, participation in Maintenance of Certification (MOC) or Osteopathic Continuous Certification (OCC), formal hospital, clinic, or payer quality improvement/re-credentialing programs should satisfy the requirements of MOL.
b. Any MOL educational activity under consideration should be developed in collaboration with physicians, evidence-based, and specialty specific. Accountability for physicians should be led by physicians.
c. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physician's time and the impact on patient access to care, as well as a risk/benefit analysis with particular attention to unintended consequences.
d. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
e. Any MOL activity should be designed for quality improvement and lifelong learning.
f. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity for physicians who are not specialty board certified or who are not in the process of MOC/OCC, or who have not been credentialed by a hospital or a payer.

The Massachusetts Medical Society shall seek working in collaboration with the Board of Registration in Medicine and other interested parties regarding any continuing medical education requirements during the deliberation process and before enactment.
(HP)

MMS House of Delegates, 12/7/13
Reaffirmed MMS House of Delegates, 12/5/20

RESEARCH

Medical Research

The Massachusetts Medical Society in its program developments will take into consideration the importance of promoting and supporting medical research in the interest of the health and well-being of future generations. *(HP)*

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

RESIDENTS

The Massachusetts Medical Society will serve as a resource to resident/fellow members who have disputes with their residency program or teaching hospital over patient care issues or working conditions. *(HP)*

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Amended and Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society supports hospital-based house staff associations to represent house staff interest and ideas and the general planning for medical cost cutting. The MMS supports the affiliation of house staff organizations with the MMS Resident Section. *(HP)*

The Massachusetts Medical Society supports continued funding for residency training. House staff currently in training programs should not have their positions cut for reasons of cost savings. *(HP)*

MMS Council, 10/9/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society (MMS) will continue to monitor state and federal legislative and regulatory activities regarding resident physician work hours. *(D)*

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/08/09
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

The Massachusetts Medical Society (MMS) acknowledges that resident physician work hour excesses can negatively impact patient safety, the quality of patient care and resident physician health, safety, and well-being. *(HP)*

The MMS encourage all residency program directors in Massachusetts to continue to adopt resident physician work hour standards that meet evidence-based ACGME guidelines. *(HP)*

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
(Item 2 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

SURGERY

Ambulatory Surgery Centers

The Massachusetts Medical Society (MMS) supports the development and utilization of accredited freestanding ambulatory surgery centers as part of a multiplicity of patient care delivery options, including physician office practices and outpatient hospital care for the provision of ambulatory surgery services as a mechanism to control health care costs, ensure access to care, and provide quality patient care in the Commonwealth. *(HP)*

The MMS supports state and federal legislation that advocates for the development and utilization of accredited freestanding ambulatory surgery care centers but does not impose Determination of Need and clinic licensing standards for physician office practices and is consistent with meeting the goals of controlling health care costs, ensuring access to care, and providing quality care, however, not to imply any MMS position on "niche" or specialty hospitals. *(D)*

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Laser Surgery

Laser surgery is a type of surgery using laser technology to cut or alter living tissue. The Massachusetts Medical Society adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery, or by other categories of practitioners currently licensed by the state to perform surgery as of January 1, 1992. *(HP)*

MMS Council, 5/8/92
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Outpatient Surgery

The Massachusetts Medical Society (MMS) will continue to collaborate with the Massachusetts Board of Registration in Medicine (BRM) regarding the endorsement of the MMS Office-Based Surgery Guidelines for surgery and anesthesia in the office-based setting. *(D)*

The MMS reaffirms its existing policy adopted at I-01 that these practice guidelines are not intended to be unique or exclusive indicators of appropriate care. Any physician should be able to demonstrate that the care rendered is safe and appropriate, even if it may vary from the guidelines in some respects. *(HP)*

The MMS believes that surgical and anesthesia care, regardless of where performed or by whom, should be provided in accordance with accepted standards of practice and in a manner that insures the safety of the patient during the performance of surgery, administration of and recovery from anesthesia, and at the time of discharge from the facility. *(HP)*

The MMS will work to refine the guidelines for surgery and anesthesia in the office-based setting on an ongoing basis as needed and forward the revisions to the BRM for incorporation. *(D)*

MMS House of Delegates, 5/31/02
(Items 2, 5, 7, and 8 of Original: Sunset)
Reaffirmed (and Item 1 Amended and Reaffirmed) MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

The MMS will continue to work with the Board of Registration in Medicine (BRM) to learn about their concerns, issues, and plans regarding office-based surgery. *(D)*

The MMS will continue to communicate with relevant national and local specialty societies and to locate current statistics regarding office-based surgery trends in Massachusetts. *(D)*

Practice guidelines are not intended to be unique or exclusive indicators of appropriate care. Any physician should be able to demonstrate that the care rendered is safe and appropriate, even if it may vary from the guidelines in some respects. *(HP)*

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
(Additional Items Sunset, 5/9/08)
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The MMS shall continue to monitor and evaluate existing and developing legislation in other states regarding office-based surgery, as well as evidence-based standards of care regarding office-based surgery, in order to bring that knowledge forward to the legislators, where appropriate. *(D)*

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/21/22

Robotic Surgery/Training

The MMS opposes efforts of the legislature to develop training protocols, certification and establishing guidelines for surgeon training and experience for the use of robotic surgery. *(D)*

MMS House of Delegates 5/19/12
Reaffirmed MMS House of Delegates, 5/4/19

Standards of Care

The Massachusetts Medical Society (MMS) recognizes that minimum frequency standards may be appropriate for some surgical procedures. *(HP)*

The MMS will continue to monitor the literature and physician feedback concerning the impact and ethic of performing surgical procedures as it relates to surgical volume. *(D)*

The MMS will continue to monitor and provide feedback, when appropriate, to relevant agencies as they develop standards regarding surgical competency and minimum frequency. *(D)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

TECHNOLOGY

Electronic Mail

The Massachusetts Medical Society (MMS) recommends that physicians who choose to use e-mail, reference the American Medical Informatics Association (AMIA) Guidelines in Developing Procedures for Their Own Practices. *(HP)*

The MMS advises physicians who choose to use e-mail that this form of communication should not be used for urgent requests or conditions, and that physicians should advise their patients and colleagues of the same. *(HP)*

The MMS should advise physicians who choose to use e-mail that the technology commonly employed does not currently ensure the security of such transmissions, unless specific measures are taken to ensure proper authentication and encryption. *(HP)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Information Technology Policy and Principles

The Massachusetts Medical Society should support the following information technology principles and policy:

a) Physicians should have direct control over choice and management of the information technology used in their practices.
b) Information technology available to physicians must be safe, effective and efficient.
c) Information technology available to physicians should support the physician's obligation to put the interests of patients first.
d) Information technology available to physicians should support the integrity and autonomy of physicians.
e) Information technology should support the patient's autonomy by providing access to that individual's data.
f) There should be no institutional or administrative barriers between physicians and their patients' health data.
g) Information technology should promote the elimination of health care disparities.

(HP)

MMS House of Delegates, 5/7/16
Reaffirmed MMS House of Delegates, 5/13/23

Internet/Broadband Access

The MMS will encourage health care systems, and potentially other parties, to 1) assess their community's level of access to internet-capable devices and internet connectivity as essential components of population health care systems planning to mitigate disparities and 2) support the right to maintain that access as a municipally-owned public utility. *(D)*

The MMS will advocate for affordable broadband internet access as a public utility for lower-income, historically marginalized, senior, and rural citizens and in underserved Massachusetts communities. *(D)*

The MMS will advocate for national legislation to remove regulations and barriers to municipal broadband services for lower-income, historically marginalized, senior, and rural citizens. *(D)*

MMS House of Delegates, 12/4/21

The MMS recognizes that internet access is a social determinant of health. *(HP)*

The MMS supports universal access to broadband internet. *(HP)*

The MMS will advocate for legislation, rules, or regulations to reduce barriers and increase access to broadband internet, such as federal, state, and local funding of broadband internet to reduce price, the establishment of automatic applications for internet assistance programs, the establishment of digital literacy education programs, and ensuring access to internet capacity sufficient for all members of a household. *(D)*

MMS House of Delegates, 5/8/21

Meaningful Use Requirements
The Massachusetts Medical Society will advocate for a more open, affordable process to meet technology mandates imposed by regulations and mandates; e.g., that all Direct secure email systems, mandated by Meaningful Use stage 2, including health information exchanges and electronic health record systems, allow a licensed physician to designate any specified Direct recipient or sender without interference from any institution, electronic health record vendor, or intermediary transport agent. *(D)*

MMS House of Delegates, 12/7/13
(Item 1: Auto-Sunset Time-Specific Directive Completed 12/7/13)
Reaffirmed MMS House of Delegates, 12/5/20

Social Media
MMS Social Media Guidelines for Physicians

Carefully planned and professionally executed participation in social media by physicians is professionally appropriate, and can be an effective method to connect with colleagues, advance professional expertise, educate patients, and enhance the public profile and reputation of our profession.

Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must not post any content that could be used to directly or indirectly reveal a patient's identity, including general identifiers that are trackable, such as day of encounter in combination with gender, age, and presenting complaint. If a patient can easily identify themselves in a social media post and they have not consented to sharing details of the case, including imaging, labs, or diagnosis, that content could potentially represent a violation of medical ethics.

Physicians must recognize that personal and professional online content can have a significant impact on public trust in the medical profession, both positively and negatively. The content that physicians post online may also influence their reputations among patients and colleagues, and may have consequences for their medical careers, particularly for physicians in training and medical students.

When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, it is highly likely that content will remain there indefinitely and may reach a wider audience than intended. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines, just as they would in any other context.

To maintain appropriate professional boundaries, it is recommended that physicians separate personal and professional content online, where technically feasible. Physicians should accept patient online invitations to connect only on a physician's professional or a practice's social media account and should not accept invitations from patients to connect on their personal accounts.

Physicians' existing professional responsibility to hold their colleagues accountable for maintaining the profession's code of ethics (e.g., AMA position on the necessity of reporting a colleague's unethical conduct) extends to behavior in online communities. Thus, when physicians see content posted by colleagues that appears unprofessional, they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

Physicians must disclose all relationships they have with regard to the maker or provider of products and services they review or discuss in online communities. This includes discussions and reviews of products and services provided to the physician for free.
(HP)

That the Massachusetts Medical Society will broadly disseminate the guidelines on the professional use of social media to its membership. *(D)*

MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 12/5/15
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Technology in Health Care *(Please See Additional Policies under Health Care Delivery)*
The MMS adopts the following statement on the interoperability of medical devices:

> The MMS believes that intercommunication and interoperability of electronic medical devices (e.g., noninvasive blood pressure cuffs, EKGs, pulse oximeters) could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. The MMS also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges, as well. The development of standards and production of interoperable equipment protocols should recognize patient safety, efficiency, and outcome benefit. *(HP)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society supports, in principle, the development of new mechanisms for the objective evaluation of health care technologies and it expresses hope that such mechanisms will include means for hastening the proper evaluation and introduction of new technologies, for example, providing for interim payment for new health care technologies which are undergoing carefully planned evaluation. A similar approach should, in due course, be applied to selected "accepted" health care technologies. *(HP)*

MMS Council, 10/12/83
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

TOBACCO/SMOKING

Anti-Smoking Poster Contest
The Massachusetts Medical Society and the Massachusetts Medical Society Alliance will sponsor an annual, statewide elementary school anti-smoking poster contest. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Cigarette Packing/Cancer Screening Information
The MMS will advocate for information about lung cancer screening to be included within cigarette packages. *(D)*

The MMS will work with the AMA to advocate for information about lung cancer screening to be included within cigarette packages. *(D)*

The MMS supports the inclusion of lung cancer screening information within cigarette packages. *(HP)*
MMS House of Delegates, 12/9/23

E-Cigarettes, Nicotine Liquids, and Personal Electronic Vaporizers *(Please See Additional Policy under Liquid Nicotine Packaging)*
The MMS opposes the marketing, sales, and use of e-cigarettes and other nicotine delivery products among youths, particularly for persons under the age of twenty-one. *(HP)*

The MMS will continue to work with Massachusetts state lawmakers and officials to develop strategies to prevent marketing, sales, and use of e-cigarettes and other nicotine delivery products among youths, particularly for persons under the age of twenty-one. *(D)*

MMS House of Delegates, 12/7/13
Amended (and Reaffirmed) by Implication MMS House of Delegates, 12/6/15
Reaffirmed MMS House of Delegates, 5/21/22

The Massachusetts Medical Society will advocate, and recommend to the American Medical Association to advocate, that the FDA extend the ban on sale or distribution of any flavored cigarettes to include menthol and mint flavors and electronic nicotine delivery systems by any retailer, retail establishment, or other person or entity to any consumer. *(D)*

MMS House of Delegates, 5/4/19
(Item 1 of Original: Auto-Sunset, Time-Limited Directive Completed: MMS House of Delegates, 12/5/20)

Government Initiatives: Sale of Tobacco Products, Advertising, Prevention
The Massachusetts Medical Society supports governmental initiatives, including full state funding of efforts of the Massachusetts anti-tobacco education campaign and FDA regulations on tobacco products that are designed to reduce access to tobacco products by persons under age 21. *(HP)*

The Massachusetts Medical Society encourages the state and federal government to ban all tobacco advertising directed toward or attractive to children. *(HP)*

The Massachusetts Medical Society encourages the state and federal government to eliminate cigarette sales from vending machines and free standing displays. *(HP)*

The Massachusetts Medical Society encourages the state and federal government to disallow sampling of tobacco products and of promotional items. *(HP)*

The Massachusetts Medical Society encourages the state government to impose strict penalties for the sale of tobacco products to persons under age 21. *(HP)*

The Massachusetts Medical Society urges the American Medical Association to encourage the state and federal government to support initiatives to reduce access to tobacco products by children and adolescents. *(HP)*

MMS House of Delegates, 11/17/95
Reaffirmed MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Items 1 and 5 Amended and Reaffirmed MMS House of Delegates, 12/6/14
Items 2-4 and 6 Amended and Reaffirmed MMS House of Delegates 5/7/16
Item 1 Amended and Reaffirmed MMS House of Delegates, 5/13/23

Liquid Nicotine Packaging *(Please See Additional Policy under Prescription and Non-prescription Drugs & Children and Youth)*
The MMS will advocate for state, local, and federal legislation and regulation to require child-resistant packaging and appropriate warning of the toxicity of this product for liquid nicotine refill products. *(D)*

MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

Point-of-Sale Tobacco Advertising (*Please Also See Government Initiatives in this Section)*
The MMS will work collaboratively with other organizations of similar interests to advocate for legislation in the Commonwealth to require tobacco vendors to remove tobacco products and all tobacco advertising from public view at cash registers and counters in all retail establishments, excluding shops that exclusively sell tobacco products. *(D)*

MMS House of Delegates, 12/4/10
Reaffirmed MMS House of Delegates, 4/29/17

Prevention
The Massachusetts Medical Society strongly supports comprehensive prevention, education, cessation, and advocacy efforts to prevent morbidity and mortality associated with tobacco use. *(HP)*

MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

Public Areas
The MMS supports state legislation to prohibit smoking or vaping in or near entrances and exits of buildings, especially those where large groups of smokers might gather, including but not limited to health care facilities, government buildings, educational institutions, shopping malls, movie theaters, indoor stadiums, and large department stores. *(D)*

MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Smokeless Tobacco
The Massachusetts Medical Society declares that snuff dipping and tobacco chewing are hazardous to health, and are certainly not safe alternatives to smoking. *(HP)*

The MMS urges physicians to make every effort to discourage the use of smokeless tobacco. *(HP)*

MMS Council, 2/13/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

Tobacco Industry
The Massachusetts Medical Society shall not undertake joint business ventures with tobacco companies or the tobacco industry or with business entities which provide significant professional representation or services to tobacco companies or the tobacco industry. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10
Reaffirmed MMS House of Delegates, 4/29/17

Tobacco Settlement Funds
The Massachusetts Medical Society (MMS) supports using a substantial portion of the multi-state tobacco Master Settlement funds for the purposes of preventing tobacco use by children and adolescents, educating the public about the health risks of tobacco use, and encouraging and assisting adult and youth smokers to quit. *(HP)*

The MMS opposes use of the Master Settlement funds for purposes unrelated to health or for replacement of funding of existing programs. *(HP)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

UNDERREPRESENTED COMMUNITIES *(Please See Additional Policies Under Medical Education)*

Clinical Trials

The MMS, as a result of acknowledging a history of abuse and racist clinical trials and research that may have caused more distrust among vulnerable populations, will identify and partner with key leaders and stakeholders in underrepresented racial/ethnic communities to improve representation/encourage participation in clinical trials. *(D)*

MMS House of Delegates, 5/8/21

Educational Opportunities and Recruitment

The Massachusetts Medical Society will support and contribute to programs to expand educational opportunities in medicine and the biomedical sciences for underrepresented minorities. *(D)*

The Massachusetts Medical Society will work with Massachusetts medical schools to promote recruitment of underrepresented minorities into medicine. *(D)*

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
Amended and Reaffirmed MMS House of Delegates, 4/28/18

Medical Interpreters

The MMS will work with other interested parties, if available, in measuring, evaluating, and improving the quality of medical care provided to patients with significant language and/or cultural barriers. *(D)*

MMS House of Delegates, 5/12/06
MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The Massachusetts Medical Society (MMS) recognizes the importance of the language barriers and cultural sensitivity and support the use of interpreter services when legally required or otherwise appropriate, whether for reasons of language, culture, or physical disability. *(HP)*

The MMS will collaborate with health plans to provide coverage for their increased costs of interpreter services necessary for providing high-quality medical care to patients who have significant language and/or cultural barriers or physical disabilities. *(D)*

MMS House of Delegates, 12/3/05
Items 1 and 3 of 3 Reaffirmed MMS House of Delegates, 5/19/12
(Item 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/4/19

Patients with Disabilities *(See Additional Policy Under Medical Education, Patients and Work Disability)*

The MMS supports and will advocate for the elimination of barriers that prevent people with disabilities from accessing and receiving appropriate care. *(HP/D)*

The MMS supports the implementation of reasonable accommodations to improve clinical care for patients with disabilities. *(HP)*

The MMS advocate for adequate resources that would improve clinical care for patients with disabilities. *(D)*

The MMS supports more accurate data collection across all health agencies on disability status, health disparities, and health outcomes for patients with disabilities, alongside compliance with ADA standards and recognition of the importance of cultural competency among physicians and other health care professionals. *(HP)*
The MMS supports appropriately risk adjusted reimbursement rates to reflect the greater time and accommodations required to care for patients with disabilities. *(HP)*

The MMS supports education for physicians and other health care professionals on the social model of disability, and accessible, trauma-informed methods to improve the experiences of patients with disabilities in health care. *(HP)*

The MMS will provide access to existing resources to support physician practices in being aware of accommodations for patients with disabilities. *(D)*

MMS House of Delegates, 5/13/23

Underrepresented and Immigrant/Migrant Populations
The MMS will encourage the state to collaborate with community leaders, nonprofit organizations, and key stakeholders in the health care system to coordinate efforts to address the medical and mental health needs of migrant families, pregnant people, children, and youth. *(D)*

The MMS supports the efforts of housing advocates to improve access to safe and stable housing for migrants. *(HP)*

The MMS will work with the MA Department of Elementary and Secondary Education, the MA Department of Public Health, other nongovernment organizations, municipalities, and physicians across the Commonwealth to:

a. Facilitate immediate enrollment of migrant children into school systems.

b. Encourage local and state programs to offer individual and group medical visits for incoming migrant youth to expedite their medical care and to document or update their immunizations.
(D)

MMS House of Delegates, 12/9/23

The Massachusetts Medical Society (MMS) will increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. *(D)*

The MMS supports the elimination of racial and ethnic disparities in health care as an issue of high priority. *(HP)*
MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11
Items 1 and 2 or Original Reaffirmed MMS House of Delegates, 4/28/18
(Item 3 of Original: Sunset)

The Massachusetts Medical Society adopts the following policy statement on The Provision of Health Care for Minority and Immigrant Populations:

> The Massachusetts Medical Society, in its role as advocate for patients, will promote a coordinated strategy for: increasing access to medical care for minority populations; heightening awareness of cultural practices through education; and creating greater opportunities for minorities and immigrants within the medical profession, including participation in the Massachusetts Medical Society.
>
> I. Increasing Access to Medical Care for Minority Populations
>
> The Massachusetts Medical Society recognizes that access to medical care is the first step to ensuring quality and improved outcomes. Therefore, the Massachusetts Medical Society will continue to strive for universal access to medical care, regardless of race, ethnicity, socio-economic status or geographic location.
>
> MMS will encourage and work with community outreach programs that address the health care needs of minority and immigrant communities. In addition, the Society will continue to develop links with community-based organizations and social service agencies to identify community-wide health problems and organize health education programs that are specifically tailored to the needs of those particular communities.
>
> II. Heightening Awareness of Cultural Practices and Barriers through Education
>
> The Massachusetts Medical Society should promote increased awareness and research among physicians and medical students on the ethnic and cultural differences between patients, physicians and other health care providers that can create barriers to good quality health care and research. The Massachusetts Medical Society supports the expansion of educational opportunities for medical students, residents, and physicians in the areas of cultural awareness and ethnic diversity.
>
> III. Creating Opportunities for More Diversity within the Medical Profession

The Massachusetts Medical Society supports the expansion of educational opportunities in biomedical careers for minority and immigrant populations.

The Society encourages physicians and health care organizations to employ culturally diverse staff, at all levels, in order to address the needs of the community.

(HP)

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
(Item III: Amended and Reaffirmed MMS House of Delegates, 5/21/11)
(Item 5 of Original, Sunset)
Reaffirmed MMS House of Delegates, 4/28/18

VIOLENCE

Domestic Violence Detection Education

The Massachusetts Medical Society supports the establishment of child abuse and domestic violence detection educational programs for physicians, physicians in training and medical students. In addition, the Massachusetts Medical Society strongly encourages and facilitates the participation of physicians, physicians in training and medical students in these programs. It is further recommended that physicians be allowed to use their participation in these programs toward the risk management requirement for relicensure. *(HP)*

MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) will continue to encourage all physicians to include routine and targeted inquiry across the lifespan screening for violence as part of their normal evaluation and prevention activities with patients. *(HP)*

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Items 2 and 3 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 4/29/17

Hate Crimes

The Massachusetts Medical Society recognizes the significant negative health outcomes and health care disparities caused by discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

The Massachusetts Medical Society strongly supports legal protections against discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

MMS House of Delegates, 5/21/11
Reaffirmed MMS House of Delegates, 4/28/18

The Massachusetts Medical Society (MMS) recognizes that hate crimes pose a significant threat to the health of individuals, families, communities, and society as a whole.

MMS House of Delegates, 11/7/98
Item 1: Reaffirmed MMS House of Delegates, 5/13/05
(Items 2-6 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/19/12
Amended and Reaffirmed MMS House of Delegates, 12/7/19

Human Trafficking

The MMS supports state and federal policies, regulations, and legislation that seek to end all forms of human trafficking (including sex and labor trafficking) and provide trafficked individuals with evidence-based and trauma-informed care services, treatment, privacy, and protections that are aligned with MMS strategic and public health priorities. *(HP)*

The MMS supports state and federal policies, regulations, and legislation that hold all entities, including businesses, accountable for human trafficking, enable local trafficking prevention task forces, and bring perpetrators of human

trafficking to justice. *(HP)*

The MMS opposes criminalization of trafficked individuals which only serves to further stigmatize and marginalize this vulnerable population. *(HP)*

MMS House of Delegates, 5/13/23

Understanding that health care professionals have a unique and potentially critical role to play in the identification, response to and prevention of human trafficking, the Massachusetts Medical Society:

- Affirms that human trafficking, in all its forms, is a detriment to the health and well-being of individuals, families, communities, and to society-at-large;
- Recommends the integration of human trafficking education into the curricula of medical school and graduate medical education programs;
- Supports the efforts of colleagues from other health professions to integrate human trafficking education into their respective school and training curricula;
- Promotes continuing medical education and training on human trafficking for all health care professionals, including training on trauma-informed, survivor-centered patient care;
- Supports interprofessional and interdisciplinary efforts to prevent human trafficking and to assist trafficked persons;
- Encourages research that advances our epidemiological understanding of human trafficking, its effects on individual and population health, best practices for human trafficking prevention, education and training of health care professionals, and clinical assessment and response to trafficked persons; and
- Promotes and supports the development and implementation of evidence-based practice setting-specific response protocols, as well as broader policies, procedures, and resource allocation to assist trafficked persons who present for care in the health care setting.

(HP)

MMS House of Delegates, 5/7/16
Amended and Reaffirmed MMS House of Delegates, 5/13/23

Interpersonal Violence

The Massachusetts Medical Society (MMS) condemns the use of all forms of violence, including force, intimidation, and coercion. *(HP)*

The MMS reaffirms its commitment to addressing and preventing interpersonal, and especially familial, violence. *(HP)*

The MMS reaffirms its commitment to improving and expanding prevention and early intervention opportunities to help thwart violence. *(HP)*

The MMS reaffirms its commitment to supporting efforts to decrease the availability of weapons used for interpersonal violence. *(HP)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Physician Safety in Provision of Gender-Affirming Care

The MMS will establish and maintain working relationships and serve as a point of contact with statewide and national reproductive health and reproductive justice organizations to engage in the feedback and advice of those organizations and collaborate in efforts to prevent and respond to threats of violence. *(D)*

MMS House of Delegates, 5/13/23

Political and Institutional Violence

In recognition of the increasing frequency of political and institutional violence involving attacks on individuals and assemblages of men, women, and children; mass casualty events; and the intergenerational toll on physical and mental health taken by such devastating acts of violence, the MMS calls for:

- Continued research that critically examines the epidemiology and root causes of political and institutional violence;
- Support for evaluative research to assess the effectiveness of interventions and containment strategies;

- Communication and implementation of effective interventions and containment strategies;
- Responses that promote peaceful dialogue within communities; and
- Clinicians' meaningful engagement with individuals, communities, institutions, and agencies to prevent further violence and reduce suffering by dialogue and other means that help all develop healthy alternative options to expressions of hate, anger, cruelty, deindividuation, and dehumanization.

(HP)

MMS House of Delegates, 5/7/16
(Reaffirmed for 1 Year Pending Review at A-24)

Sexual Violence
The Massachusetts Medical Society (MMS) affirms its commitment to addressing and preventing sexual violence assault. *(HP)*

The MMS supports the development of physician educational programs and resources, as well as patient education materials, pertaining to sexual violence assault. *(HP)*

The MMS strongly encourages and facilitates the participation of physicians, physicians-in-training, and medical students in educational programs that address sexual violence assault. *(HP)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Item 1of Original: Amended and Reaffirmed MMS House of Delegates, 5/17/14
Items 2 and 3 of Original: Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/8/21

Violence/against Physicians, Health Care Workers
The MMS will coordinate with the Commonwealth of Massachusetts on the development and implementation of legislative and statewide actions that provide support regarding threats of violence toward physicians including but not limited to those who provide services for TGD persons, reproductive care, or who advance health equity and promote public health practices. *(D)*

MMS House of Delegates, 12/10/22
(Item 1 of Original: Auto-Sunset, Time-Limited Directive Completed, MMS House of Delegates, 12/9/23)

The MMS deplores all forms of violence and terrorism against all members of society, and against the physicians and health care workers who provide medical services. *(HP)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Amended and Reaffirmed MMS House of Delegates, 12/7/19

War/Nuclear War
The MMS supports global efforts to prevent nuclear war and renounces the use of nuclear weapons. *(HP)*

MMS House of Delegates, 12/5/20
(Item 2 of Original Auto-Sunset; Time-Limited Directive Completed MMS House of Delegates, 12/4/21)

The MMS opposes the targeting of physicians and health care providers for killing, torture or capture, and treatment of them as combatants or conspirators, based upon their provision of medical care**.** *(HP)*

MMS House of Delegates, 5/11/13
Reaffirmed MMS House of Delegates, 12/5/20

The MMS adopts policy that:

- Advises the government of the United States, and all national governments, that even a limited nuclear war would have catastrophic effects on the world's food supply and would put a significant proportion of the world's population at risk from a nuclear famine;
- Urges education of physicians and the general public that the threat of a limited nuclear war is an overwhelming threat to public health; and
- Urges the government of the United States, and all national governments, to continue to work to ban the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons. *(HP)*

MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/4/19
Reaffirmed MMS House of Delegates, 5/13/23

Youth Violence

The Massachusetts Medical Society (MMS) affirms its commitment to addressing and preventing all forms of violence affecting children and youth as part of its ongoing campaign against violence.

The MMS advocates for local, state, and federal legislative and regulatory policy that supports efforts to reduce the burden of physical and psychological injury caused by violence against children and youth.

The MMS supports the development and delivery of educational programs and resources for health professionals pertaining to children and youth violence.

The MMS supports the development and distribution of patient education and public awareness materials pertaining to children and youth violence, including, but not limited to all forms of entertainment and social media.

The MMS strongly encourages and facilitates the participation of physicians, physicians-in-training, medical students, and other health care professionals in educational initiatives pertaining to children and youth violence.

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/21/22

MMS POLICY COMPENDIUM

Addendum

A) Time-Limited, Time-Specific Directives B) Directives to Sunset Upon Completion C) MMS Awards and Honors

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At A-04, the House of Delegates (HOD) adopted the following amendment to the *Procedures of the House of Delegates,* Procedure 18, Sunset Policy:

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Directives adopted by the House which contain time-limited specifics; establish task forces, committees, or other special ad hoc entities; and directives to amend the Procedures of the House of Delegates or the Bylaws shall not be subject to the seven-year sunset mechanism and shall sunset automatically at the completion of the directive or document update.

Per Bylaw 6.01, adopted at A-03, the HOD approves two general types of policy: directives and health policies. The HOD began designating these two types of policy at I-03.

At I-15, the HOD adopted BOT Report I-15 C-2, Recognition Awards, which states in part that "The Board of Trustees and its Committee on Recognition Awards shall be responsible for oversight and approval of new and existing MMS recognition awards." For tracking purposes, Appendix C outlines all MMS awards and the schedule for BOT review of each award.

The following information is divided into three appendices and is intended to inform members of the following:

- **APPENDIX A: Time-Limited, Time-Specific Directives Completed/Sunset**
  Directives adopted that are time-limited, have been completed, and have sunset.

- **APPENDIX B: Directives to Sunset Upon Completion**
  Topic areas for directives adopted at recent meetings that are due for a time-specific report back to the House of Delegates or due for implementation within a specific time, and will sunset upon completion.

- **APPENDIX C: MMS Awards and Honors**

APPENDIX A: Auto-Sunset Immediately: Time-Specific Directives Completed/Sunset (NA)

Topic	Adopted
THE REPORT The Committee on Bylaws recommends that the House of Delegates approve the following amendments to the MMS Bylaws (except as otherwise noted, added text is shown as "text" and deleted text is shown as "~~text~~"): *ITEM A*: GRWG Report A-23 C-4 [I-22 C-3]: District Leadership Council as a Standing Committee CHAPTER 4 • District Societies • • • 4.14 Officers Each district society shall elect a president; a vice-president; a secretary; a treasurer; delegates as specified in 4.15; a member and alternate member of each of the following committees of the Massachusetts Medical Society: the Committee on Legislation, ~~and~~ the Committee on Nominations, and the District Leadership Committee. • • • 4.22 Committee on Legislation Membership Members of the Committee on Legislation of the Massachusetts Medical Society shall serve one-year terms with a maximum of nine consecutive years. Alternate members of the Committee on Legislation of the Massachusetts Medical Society shall serve one-year terms with a maximum of nine consecutive years. 4.23 District Leadership Committee All officers of each district society are eligible to be members of the District Leadership Committee. Members of the District Leadership Committee shall serve one-year terms, renewable for as long as the member is an officer of a district society. • • • CHAPTER 6 • Sections • • • 6.024 Committee on Nominations One member of the Medical Student Section is entitled to serve as a member of the Committee on Nominations. Such member shall be elected annually by the Medical Students Section. 6.025 District Leadership Committee One member of the Medical Student Section is entitled to serve as a non-voting member of the District Leadership Committee. Such member shall be elected annually by the Medical Students Section. • • •	12/9/23 (pending 2024 Annual Meeting of the Society)

6.034 Committee on Nominations
One member of the Resident and Fellow Section is entitled to serve as a member of the Committee on Nominations. Such member shall be elected annually by the Resident and Fellow Section.

6.035 District Leadership Committee
One member of the Resident and Fellow Section is entitled to serve as a non-voting member of the District Leadership Committee. Such member shall be elected annually by the Resident and Fellow Section.

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CHAPTER 12 • Committees

12.01 Term and Qualifications of Committee Members

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Committee members elected by districts shall serve for terms set forth in 4.21, 4.22, and 4.23.

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12.02 Committee Member Selection
The members of the Committee on Nominations, ~~and~~ the Committee on Legislation, and the District Leadership Committee shall be appointed by the districts as provided in 4.14 and 12.041. The chair of the Committee on Nominations, the District Leadership Committee, and the Judicial Committee shall each be selected by the members of their respective committees.

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12.04 Standing Committees
Standing committees are: Bylaws; District Leadership; Ethics, Grievances, and Professional Standards; Judicial; Legislation; Medical Education; Membership; Nominations; Publications; Interspecialty; Quality of Medical Practice; Public Health; Communications; and Professional Liability. Standing committees continue from year to year and may not be established or abolished except by amending the bylaws of the Society.
12.041 Standing Committees with Members Elected by the District Societies
Each district society shall annually elect members to the following standing committees.

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12.0413 District Leadership Committee
All officers of district societies shall be eligible to be members of the District Leadership Committee. Each district society shall choose one voting member and one alternate voting member as provided in 4.14 and 4.23 and as certified by the district's president. Voting within the District Leadership Committee will be by majority vote, with one vote per district. The Medical Student Section and the Resident and Fellow Section will each be allowed one non-voting member of the District Leadership Committee, as provided in 6.025 and 6.035, respectively.

The chair and vice chair of the District Leadership Committee will be

selected by members of the committee at the first meeting of each presidential year and shall serve for a term of up to two years, renewable up to a total of four years, based on eligibility as a district officer. If a chair of the District Leadership Committee ceases to serve on the Committee prior to the expiration of their two-year term in committee leadership, then the vice chair shall assume the role of chair for the remainder of the term, and this time shall not count towards the total four years of eligibility as chair. If a vice chair of the District Leadership Committee ceases to serve on the committee prior to the expiration of their two-year term in committee leadership, then the committee members shall select a new vice chair to complete the remainder of the term in office, and this time shall not count towards the total four years of eligibility as vice chair. The charge of the District Leadership Committee shall be to ensure the ongoing strength and viability of the district societies through communication with the Presidential Officers and Board of Trustees and through discussion and submission of policy and reports to the House of Delegates. *ITEM B:* OFFICER Report A-23 C-5 [I-22 C-4]: Transformation of the Committee on Communications to Advisory Group on Communications CHAPTER 12 • Committees • • • 12.04 Standing Committees Standing committees are: Bylaws; Ethics, Grievances, and Professional Standards; Judicial; Legislation; Medical Education; Membership; Nominations; Publications; Interspecialty; Quality of Medical Practice; Public Health; ~~Communications;~~ and Professional Liability. Standing committees continue from year to year and may not be established or abolished except by amending the bylaws of the Society. • • • ~~12.04209 Committee on Communications~~ ~~The Committee on Communications shall consist of nine members. The Committee shall be responsible for working with the Society's leadership in the development of a yearly Society communication strategy to include strategic messages, programs, and campaigns directed at all of the Society's audiences.~~ 12.0420910~~10~~ Committee on Professional Liability The Committee on Professional Liability shall consist of thirteen members. It shall: Advise the Officers, Trustees, House of Delegates, and/or membership on matters related to Professional Liability; monitor the professional liability climate and participate in activities to improve and reform it; and educate the members on changing aspects of professional liability. *(D)*	
That the Committee on Nominations recommends approval by the House of Delegates to amend items (c) of the Procedures of the Committee on Nominations (*ATTACHMENT I in the MMS Bylaws*) to read as follows: (c) That candidates for nomination for all positions for which the	12/9/23

Committee on Nominations has responsibility be submitted to the Committee on Nominations on or before the date established by the Committee. Timely notice of such nomination deadline dates shall be provided by the Committee on Nominations. In the event of the withdrawal of an incumbent candidate after the nomination process has closed, or there are no nominations for a position, or in the event that the Committee on Nominations decides that additional candidates are needed for a specific position, the Committee on Nominations may, at its discretion, reopen the nominations process for that specific position only. This must occur at least 10 days before the opening of the House of Delegates at which the election will be held. Notification of the re-opening of nominations will be made to the membership on the next day following the Committee on Nominations decision to reopen the nomination process, following outreach procedures previously set forth in (b). . . . *(D)*	
That the MMS amend its BOT policy adopted at A-22 to read as follows: That the MMS request that MMS Bylaws be amended to implement the following: The Board of Trustees shall consist of a trustee from each of six regions elected for a term of three years and may be re-elected for one additional term, five statewide trustees elected for a term of three years and may be re-elected for one additional term. […] f. That the MMS establish six regions. h. That the MMS create six regional trustee positions on the Board of Trustees. Each regional trustee shall serve for a term of three years and may be re-elected for one additional term. […] i. That the MMS create five statewide trustee positions on the Board of Trustees. Each statewide trustee shall serve for a term of three years and may be re-elected for one additional term. o The Committee on Nominations will submit a slate to the HOD for a vote for open statewide trustee positions for election to a three-year term each. […] (D)	12/9/23 (Pending Bylaws Amendment)
That the following individuals be recommended to the House of Delegates at Annual 2023 as delegates-at-Large: Karen H. Antman, MD, Provost, Boston University Medical Campus and Dean, Boston University Chobanian & Avedisian School of Medicine; Sandro Galea, MD, MPH, DrPH, Dean, Boston University School of Public Health; George Q. Daley, MD, PhD, Dean, Harvard Medical School;	5/13/23

Helen Boucher, MD, Dean, Tufts University School of Medicine; and Terence R. Flotte, MD, Dean, T.H. Chan School of Medicine and Provost and Executive Deputy Chancellor, University of Massachusetts Chan Medical School; and Anna Maria Siega-Riz, PhD, Dean of the School of Public Health and Health Sciences, University of Massachusetts, Amherst. *(D)* That the following individuals receive a complimentary membership to the MMS for 2023: Karen H. Antman, MD, Provost, Boston University Medical Campus and Dean, Boston University Chobanian & Avedisian School of Medicine; Sandro Galea, MD, MPH, DrPH, Dean, Boston University School of Public Health; George Q. Daley, MD, PhD, Dean, Harvard Medical School; Helen Boucher, MD, Dean, Tufts University School of Medicine; and Terence R. Flotte, MD, Dean, T.H. Chan School of Medicine and Provost and Executive Deputy Chancellor, University of Massachusetts Chan Medical School. *(D)*	
That the President of the Massachusetts Medical Society establish a Climate Change Advisory Group with the purpose of developing an action plan to reflect the Society's commitment to address the impact of climate change on patients' health, the MMS community and health care industry. *(D)*	(Accepted MMS Board of Trustees, 4/5/23) Approved MMS House of Delegates, 5/13/23

[amendment from HOD shown as "*text*"]: 5/13/23

The Committee on Bylaws recommends the following changes to the Bylaws, to be effective as of the start of the 2023–2024 Presidential Year *with the exception of changes to the positions of Vice President, Assistant Secretary Treasurer, and the Immediate Past President, which will be effective at the start of the 2024–2025 Presidential Year.*

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CHAPTER 4 • District Societies

4.10 Existing and New Districts
The Massachusetts Medical Society is composed of its constituent district medical societies.

The House of Delegates may from time to time establish new district societies upon application of not less than 60 members residing or practicing in any given area and it may alter boundaries of existing district societies or discontinue district societies, subject to approval by a two-thirds vote of the members of the affected district(s) in attendance at the annual meeting of the district(s).

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4.17 Trustees
The members of each district society shall elect ~~two~~ one of their number to serve as trustee ~~and alternate respectively~~ of the Board of Trustees. Trustees ~~and alternates~~ so elected, for the duration of their term, shall become delegates ex-officio as provided in 7.02.

Trustees shall serve for a term of two years and may be re-elected for three additional terms, or eight total years, after which they are ineligible for re-election. ~~Alternate trustees shall serve for a term of two years and may be re-elected for three additional terms, or eight total years, after which they are ineligible for re-election.~~ Total years served includes all time served, regardless of when it was served, except that total years served shall not include time served as an ex-officio member of the Board of Trustees and time served filling a vacancy on the Board of Trustees as provided for in 4.171.

The eight-year term limit for trustees ~~and alternate trustees~~ shall become effective as of the close of the 2015 annual meeting of the Society.

Past presidents of the Society shall be excluded from serving as district-elected trustees ~~or alternates~~ of the Board of Trustees.

4.171 Vacancies
Vacancies that occur in the office of trustee ~~or alternate trustee~~ of the Board of Trustees shall be filled ad interim by vote of the delegates of the district society.

4.18 Secretary
The secretary of each district society shall promptly after its annual meeting transmit to the Executive Vice President on appropriate forms the names and addresses of officers, delegates and members of committees elected under 4.14, and the names of the trustee ~~and alternate~~ elected under 4.17.

The secretary shall arrange for the filling of vacancies in the office of trustee ~~or alternate trustee~~ of the Board of Trustees in the manner prescribed in 4.171.

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CHAPTER 6 • Sections

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6.02 Medical Student Section
The Medical Student Section is composed of members of the Massachusetts Medical Society who are enrolled in medical school.

6.021 House of Delegates Representation Medical Student Section is entitled to two student representatives from each duly accredited medical school in the Commonwealth of Massachusetts in the House of Delegates. Such delegates shall be elected annually by the medical student members of the Massachusetts Medical Society of the respective schools. The medical students selected shall be members of the Massachusetts Medical Society. If such delegate is unable to participate in either the Annual or Interim meeting of the House of Delegates, a substitute delegate for attendance at the meeting may be appointed from the eligible membership by the section chair. The Medical Student section primary and secondary trustees ~~and alternate~~ as provided for in 6.023 shall be made ex-officio delegates for the duration of their term.

6.022 Term
The delegates shall serve for one year.

6.023 Trustees
The Medical Student Section shall elect two of their members who are either current or former delegates to serve as primary and secondary trustees ~~and alternate~~ respectively of the Board of Trustees.

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6.03 Resident and Fellow Section
The Resident and Fellow Section is composed of physicians in training who are members of the Massachusetts Medical Society. As used in these Bylaws with reference to the Resident and Fellow Section, the term “fellow” means “fellow” as defined by the Accreditation Council of Graduate Medical Education.

6.031 House of Delegates Representation
The Resident and Fellow Section is entitled to eight representatives in the House of Delegates, each of whom is a resident or fellow. Such delegates shall be elected annually by the Resident and Fellow Section of the Massachusetts Medical Society. If such delegate is unable to participate in either the Annual or Interim meeting of the House of Delegates, a substitute delegate for attendance at the meeting may be appointed from the eligible membership by the section chair.

6.032 Term
The delegates shall serve for one year.

6.033 Trustees
The Resident and Fellow Section shall elect two of the eight delegates to serve as a primary and secondary trustee ~~and alternat~~e respectively of the Board of Trustees.

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CHAPTER 7 • The House of Delegates

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7.02 Composition
The House of Delegates is composed of delegates elected by the district societies as provided in 4.15 and in addition:

(1) One delegate from each designated medical specialty society as provided in 5.03.
(2) Two delegates duly authorized from the student membership in each medical school in the Commonwealth of Massachusetts and the Medical Student Section primary and secondary trustee ~~and alternate~~ as provided in 6.021.
(3) Eight delegates from the Resident and Fellow Section as provided in 6.031.
(4) One delegate from the Organized Medical Staff Section of the Society as provided in 6.041, one delegate from the Academic Physician Section of the Society as provided in 6.051, one delegate from the International Medical Graduate Section as provided in 6.061, one delegate from the Minority Affairs Section as provided in 6.071, one delegate from the Women Physicians Section as provided in 6.081, and one delegate from the Early Career Physicians Section as provided in 6.091.
(5) The President, President-elect, ~~Vice President,~~ Secretary-Treasurer, ~~Assistant Secretary-Treasurer,~~ Speaker and Vice Speaker.
(6) The president and secretary of each district medical society.
(7) Chairs of all standing committees of the Society.
(8) Past Presidents of the Society.
(9) Delegates-at-large, as recommended by the Board of Trustees, may be elected by the House of Delegates. Delegates-at-large must be members of the Massachusetts Medical Society, must be elected individually, and will have the right to vote.
(10) The President of the Massachusetts Medical Society Alliance.
(11) Trustees ~~and alternates~~ from each district medical society as provided in 4.17.
(12) The President of the Boston Medical Library, if also a member of the Society.

7.03 Meetings
The House of Delegates shall meet twice a year for two days. On the first day of the annual meeting and at an interim meeting, a number of concurrent reference committees will be organized and scheduled by the Speaker. These reference committees will hear testimony and make recommendations on all resolutions and reports presented to the House of Delegates. On the second day, the House of Delegates will meet to take action on the reference committee recommendations. Special meetings may be called at any time by the President and shall be called by vote of the House of Delegates or upon written request of 10 delegates.

Meetings of the House of Delegates shall be held in such places as determined by the President ~~and~~, President-elect and ~~Vice~~ Immediate Past President in consultation with the Speaker and Vice Speaker.

Deliberations of the House of Delegates shall be governed by such rules as it may from time to time adopt and in accordance with the provisions of Chapter XVIII of these bylaws.

Seventy-Five delegates shall constitute a quorum.

7.04 Elections
The House of Delegates shall elect annually:
(1) A President-elect, ~~a Vice President,~~ a Secretary-Treasurer, ~~an Assistant Secretary-Treasurer,~~ a Speaker, and a Vice Speaker.

(2) AMA delegates and alternate AMA delegates to the House of Delegates of the American Medical Association in accordance with the bylaws of that Association. Subject to the provisions of 10.03(7), the delegation shall include a member of the Medical Student Section and a member of the Resident and Fellow Section, each of whom is a Regular member.

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CHAPTER 8 • Board of Trustees

8.01 Composition

The Board of Trustees shall consist of a trustee from each district society chosen as provided in 4.17; the President, the President-elect, ~~the Vice President,~~ the immediate past President, the Secretary-Treasurer, ~~the Assistant Secretary-Treasurer,~~ one member of the Resident and Fellow Section as provided in 6.033, one member of the Medical Student Section as provided in 6.023, ~~the president of the Massachusetts Medical Society Alliance,~~ the chair of the Committee on Finance, the Speaker, and a non-physician member chosen according to procedures described in Section 12.042(2) ~~without the right to vote, and the Vice Speaker without the right to vote. Each district shall elect an alternate trustee, in accordance with 4.17~~; the Medical Student Section shall elect ~~an alternate~~ a primary and a secondary trustee, in accordance with 6.023; and the Resident and Fellow Section shall elect ~~an alternate~~ a primary and a secondary trustee, in accordance with 6.033. Each ~~such alternate~~ secondary trustee shall be eligible to serve in the event of the absence of the ~~alternate~~ secondary trustee's respective primary trustee.

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8.03 Specified Duties

(1) The Board of Trustees shall be responsible for strategic planning for the Society.
(2) The Board of Trustees shall oversee the duties of the Executive Vice President.
(3) The Board of Trustees shall employ and determine the conditions of employment of the Executive Vice President and such other administrative officers as it may authorize from time to time.
(4) The Board of Trustees shall indicate those members who are to be deprived for nonpayment of dues as provided in 3.401.
(5) The Board of Trustees, after receiving recommendations from the Judicial Committee, shall act upon appeals from applicants who allege that they have been unfairly denied membership in the Society as provided in 3.33 and 12.0424.
(6) The Board of Trustees shall try any officer of the Society charged with malfeasance in accordance with the procedure outlined in 13.02.
(7) The Board of Trustees shall approve interim committee appointments as provided for in 12.02.
(8) The Board of Trustees shall make recommendations to the House of Delegates for the election of delegates-at-large as provided in 7.02(9).
(9) The Board of Trustees may act upon matters of indemnification as provided in Chapter XVI.
(10) The Board of Trustees may designate employees of the Society or of the district societies and agents of the Society, individually or by class, as being entitled to indemnification under Chapter XVI.
(11) The Board of Trustees may create subcommittees of trustees to fulfill its duties.
(12) The Board of Trustees shall approve or disapprove recommendations of the Committee on Finance for the acquisition of real estate.

(13) The Board of Trustees may remove any elected trustee ~~or alternate trustee~~ of the Society for cause in accordance with the procedure outlined in 13.03.
(14) The Board of Trustees shall approve the appointment of representatives to other organizations, as it deems appropriate.
(15) The Board of Trustees shall annually review the activities of the Boston Medical Library and shall invite the President of the Boston Medical Library (or designee) to present an annual summary.

8.04 Meetings
The Board of Trustees shall hold at least six meetings annually. The time and place of each meeting shall be determined by the Board.

Special meetings may be called at any time by the President and shall be called upon written request of five members of the Board.

8.041 Notice
Notice of each stated and special meeting shall be given at least one week in advance. The notice shall contain a tentative agenda, but other business may be transacted. Notice is considered to have been given if delivered in person, by email or other electronic means, by telephone, by fax or by mail. Notice of any meeting need not be given if waived in writing or by telegram before, during or after the meeting, and attendance at any meeting shall constitute waiver of notice of that meeting.

8.042 Quorum
~~Twenty (20)~~ A majority of voting members of the Board of Trustees shall constitute a quorum.

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8.08 Committee on Finance
The Board of Trustees shall have a Committee on Finance, which shall consist of nine members each of whom shall have been a Regular member of the Society for at least five years. In addition, the Secretary-Treasurer ~~and the Assistant Secretary-Treasurer~~ shall ~~each~~ be a member ex-officio of the Committee. In addition, one member of the Medical Student Section and one member of the Resident and Fellow Section shall be a member of the Committee, but neither shall be included in the determination of the number of members to which the Committee is entitled.

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8.11 Term of Outside Non-Physician Trustee
The outside non-physician member of the Board of Trustees shall serve for an initial three-year term, with a formal process for evaluation of the position before the end of that three-year initial term.

CHAPTER 9 • Officers

9.01 Positions
Officers of the Society shall be a President, President-elect, Immediate Past President, ~~Vice President~~, Secretary-Treasurer, ~~Assistant Secretary-Treasurer,~~ Speaker and Vice Speaker elected by the House of Delegates as provided in 10.00.

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9.03 Terms of Office
Each officer shall hold office from the close of the Annual Session of the Society during which the officer takes office until the close of the following Annual Session or until the officer's successor is installed in accordance with 9.04. The term of office of the

Secretary-Treasurer, ~~Assistant Secretary-Treasurer,~~ Speaker and Vice Speaker shall be limited to three consecutive years.

9.04 Vacancies

9.041 President
The President-elect shall immediately assume office.
9.042 President-elect
The vacancy shall remain unfilled until the next meeting of the House of Delegates at which time it shall elect a President-elect.

~~9.043 Vice President~~
~~The President will nominate from among the members of the Board of Trustees (excluding alternates) a candidate to become Vice President. The appointment must be approved by a majority of the Board of Trustees.~~

9.043 Immediate Past President
The President will nominate from among the members of the Advisory Committee established in Section 12.06 a candidate to assume the role of Immediate Past President. The appointment must be approved by the Committee on Nominations.

9.044 Secretary-Treasurer
~~The Assistant Secretary-Treasurer shall immediately assume the office.~~ The Office of Secretary-Treasurer shall be filled according to the process described in 10.021, which states that "[t]he President may make interim appointments to fill vacancies in any Offices for which succession is not specifically provided in these bylaws."

~~9.045 Assistant Secretary-Treasurer~~
~~The House of Delegates shall at its next meeting select a member to fill the unexpired term.~~

~~9.046~~ 9.045 Speaker
The Vice Speaker shall immediately assume office.

~~9.047~~ 9.046 Vice Speaker
The House of Delegates shall at its next meeting elect a delegate to fill the unexpired term.

~~9.048~~ 9.047 Other Vacancies
If a vacancy occurs in any Office, for which succession is not specifically provided for in these bylaws, the House of Delegates shall at its next meeting elect a successor to fill the unexpired term.

9.05 Duties and Powers

9.051 President
The President shall:
(1) Preside as the chair of the Board of Trustees as provided in 8.05.
(2) Preside at meetings of the Society and the Board of Trustees except as provided in 13.0241.
(3) Approve all bills against the Society in excess of an amount which shall be set by the Board of Trustees after their validity has been attested to by endorsement by the officer, delegate or chair of the committee that has incurred the indebtedness specified in the bill.
(4) Bring legal action, in the name of the Society, when so directed by the Board of Trustees.

(5) Sign the certificates of membership of all new members after proper approval and endorsement.
(6) Make appointments to fill vacancies in committees appointed by the President or President-elect and fill vacancies as a result of action taken by the President, as provided in 12.00.
(7) Appoint special committees authorized by the House of Delegates, as provided in 12.051.
(8) Be a member ex-officio of all committees of the Society, except the Committee on Nominations and the Judicial Committee.
(9) Report on the state of the Society at the Annual Meeting of the Society.
(10) In the event of the death or incapacity of the President-elect, at the annual meeting of the House of Delegates, nominate members of standing and special committees as provided in 12.042.
(11) Have the authority to call a meeting of any committee of the Society.
(12) Have the authority to create task forces as provided in 9.06.
(13) Shall appropriately implement the mandates of the House of Delegates.
(14) Shall be the official spokesman for the Society.
(15) The President, President-elect and ~~Vice~~ Immediate Past President shall select the Orator, subject to confirmation by the Board of Trustees.

9.052 ~~Vice~~ Immediate Past President
The ~~Vice~~ Immediate Past President shall:
(1) Be a member ex-officio of all committees except the Committee on Nominations and the Judicial Committee.
(2) The President, President-elect and ~~Vice~~ Immediate Past President shall select the Orator, subject to confirmation by the Board of Trustees.
(3) Perform such other duties and responsibility as assigned by the President.

9.053 President-elect
The President-elect shall:
(1) Act on behalf of the President as directed by that officer and in so doing shall be considered to represent the President. In the absence of the President, the President-elect shall perform the duties of the President.
(2) Be a member ex-officio of all committees except the Committee on Nominations and the Judicial Committee.
(3) Appoint:
(a) The chair of the Committee on Legislation.
(b) The chairs and members of standing committees for the ensuing year as provided in 12.042.
(c) The members of the special committees as are approved by the House of Delegates as provided in 12.0511.
(4) The President, President-elect and ~~Vice~~ Immediate Past President shall select the Orator, subject to confirmation by the Board of Trustees.

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~~9.055 Assistant Secretary-Treasurer~~
~~The Assistant Secretary-Treasurer shall:~~
~~(1) Act on behalf of the Secretary-Treasurer as directed by that officer.~~
~~(2) Assume the duties of the Secretary-Treasurer in the event of the absence, death or incapacity of that officer.~~
~~(3) Be a trustee of the Board of Trustees and a member of the Committee on Finance and a member ex-officio, without the right to vote, of all other committees except the Committee on Nominations and the Judicial Committee.~~

~~9.056~~ 9.055 Speaker

The Speaker shall preside over meetings of the House of Delegates, shall follow the agenda for the House of Delegates, appoint reference committees and assign resolutions and reports to the proper reference committee in accordance with 7.03 and shall be a trustee of the Board of Trustees ~~without the right to vote~~.

~~9.057~~ 9.056 Vice Speaker
The Vice Speaker shall (1) perform the duties of the Speaker in the absence of the Speaker or at the designation of the Speaker~~, (2) be a trustee of the Board of Trustees without the right to vote and (3)~~ and (2) convene the organizational meeting of the Committee on Nominations and preside until a chair is elected in accordance with 12.0412(2).

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CHAPTER 10 • Elections

10.01 Annual Elections
Annual elections shall be conducted by the House of Delegates in the following manner:

10.011 Nominations
Nominations for President-elect, ~~Vice President,~~ Secretary-Treasurer~~, Assistant Secretary-Treasurer~~, Speaker~~,~~ ~~and~~ Vice Speaker, non-physician member of the Board of Trustees, and delegates and alternate delegates to the American Medical Association shall be submitted to the delegates by the Committee on Nominations in accordance with 12.0412(2). There will be one slate offered by the Committee on Nominations.

In addition, nominations for any position may be made during a meeting of the House of Delegates. Such nominations shall be subject to the provisions of 10.03(4) and the restriction that advance written notice of any nomination is received by the Speaker before 5p.m., at the Society's Offices, of the fifth business day before the opening of the meeting of the House of Delegates at which the nomination will be made. Such notice must include ten (10) Massachusetts Medical Society members' support of the nomination, signed by the member and submitted in writing, or submitted by verified e-mail or fax.

10.012 Voting
The offices of President-elect, ~~Vice President,~~ Secretary-Treasurer, ~~Assistant Secretary Treasurer,~~ Speaker, and Vice Speaker shall be voted on individually. Voting shall be by ballot unless a single candidate is nominated in which case a voice vote may be taken.

10.013 Election
There will be two separate elections, one for the President-elect, ~~Vice President,~~ Secretary-Treasurer, ~~Assistant Secretary-Treasurer,~~ Speaker, ~~and~~ Vice Speaker, and non-physician member of the Board of Trustees, and one for the AMA delegation in accordance with 12.0412(2).
The annual elections will be as follows: annual meeting of the House of Delegates for the President-elect, ~~Vice President,~~ Secretary-Treasurer, ~~Assistant Secretary-Treasurer,~~ Speaker, ~~and~~ Vice Speaker, and non-physician member of the Board of Trustees, to take effect after the annual meeting; interim meeting of the House of Delegates for the AMA delegates, to take effect the next January 1st.

A majority of the votes cast shall be necessary to elect. If on any ballot no nominee receives a majority of the votes cast, the nominee receiving the

smallest number of votes shall be eliminated and the balloting shall proceed in that manner until a candidate obtains a majority.

10.014 Automatic Accession to the Presidency At the close of the term of office of the President-elect as set forth in 9.03, the President-elect shall automatically accede to the office of President.

10.02 Special Elections

Special elections to fill vacancies may be conducted at any stated meeting of the House of Delegates. They shall be conducted in the following manner:

10.021 Interim Appointments

The President may make interim appointments to fill vacancies in any Offices for which succession is not specifically provided in these bylaws.

10.022 Election

Voting and election shall be as provided in 10.012 and 10.013.

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CHAPTER 12 • Committees

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12.04 Standing Committees

Standing committees are: Bylaws; Ethics, Grievances, and Professional Standards; Judicial; Legislation; Medical Education; Membership; Nominations; Publications; Interspecialty; Quality of Medical Practice; Public Health; Communications; and Professional Liability. Standing committees continue from year to year and may not be established or abolished except by amending the bylaws of the Society.

12.041 Standing Committees with Members Elected by the District Societies

Each district society shall annually elect members to the following standing committees.

12.0411 Committee on Legislation

The Committee on Legislation shall be composed of a chair and a vice chair, both appointed from among the committee members by the President-elect, and one member and alternate from each district society as provided in 4.14 and 4.22. When an immediate decision is needed concerning legislative action, the decision shall be made by the President (or in the absence of the President, by the President-elect; or in the absence of the President and President-elect by the ~~Vice~~ Immediate Past President) in consultation with the committee chair (or in the absence of the committee chair with the vice chair) of the Committee on Legislation.

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12.0412 Committee on Nominations

The Committee on Nominations shall consist of one delegate and alternate from each district society as provided in 4.14 and 4.21, one member of the Medical Student Section, and one member of the Resident and Fellow Section, as provided in 6.024 and 6.034, respectively. The committee chair shall be elected by the members of the committee.

(1) Qualifications of Committee Members.

Each committee member and each alternate member must be a delegate to the House of Delegates and have held this office for at least two years.

A current officer of the Society or AMA delegate cannot be a member of the Committee on Nominations.

A committee member must resign from the committee before becoming a candidate to be a Society officer or an AMA delegate.

(2) Meetings and Actions of the Committee.

The first meeting shall be called by the Vice Speaker for the purpose of organizing the committee and electing a chair. The Vice Speaker shall preside until a chair is elected. The meeting shall be within thirty days after the annual meeting of the Society.

The full Committee on Nominations will interview all candidates.

No action at any meeting of the committee, when it acts on nominations, shall be official unless that meeting is attended by the member or alternate of at least three-quarters of the district medical societies.

The Committee on Nominations will meet, accept and evaluate nominations and vote on one slate of nominees in accordance with Procedures of the Committee on Nominations. Amendments to the Procedures of the Committee on Nominations will be proposed by the Committee on Nominations and approved by the House of Delegates.

Nominations for officers, delegates, and alternate delegates to the American Medical Association (AMA) shall be submitted to the House of Delegates (HOD) by the Committee on Nominations.

Nomination of the outside non-physician member of the Board of Trustees shall be submitted to the House of Delegates by the Committee on Nominations. Such outside Trustee will have an initial term of three years, with a formal process for evaluation at the conclusion of the initial term.

There will be two separate elections, one for Officers and the non-physician member of the Board of Trustees, and one for the AMA delegation. The annual elections will be as follows: annual meeting of the HOD for the Officers and the non-physician member of the Board of Trustees to take effect after the annual meeting; interim meeting of the HOD for the American Medical Association (AMA) delegates, to take effect the next January 1st.

12.042 Standing Committees Appointed by the President-elect

The chair (except for the Judicial Committee) and members of the following standing committees shall be appointed annually by the President-elect subject to approval by the House of Delegates.

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12.04204 Judicial Committee

The Judicial Committee shall consist of seven members, a first alternate and a second alternate, each of whom shall have been a Regular member of the Society for at least five years. The chair shall be elected by the committee members.

A quorum shall consist of 5 members.

The Judicial Committee shall be the final authority in interpretation of the bylaws and the Code of Ethics of the Society.

The Judicial Committee shall consider appeals from denial of reinstatement under 3.703 on an expedited basis, and shall, upon such investigation as it deems necessary or appropriate, render its decision in such matters, which shall be final.

The Judicial Committee shall investigate all properly presented charges of impeachment against officials of the Society and determine whether or not they shall be submitted to the Board of Trustees for hearing as provided in 13.023 and shall participate in such hearings as provided in 13.0241.

The Judicial Committee shall investigate all properly presented charges of removal of elected trustees ~~and alternate trustees~~ of the Society and determine whether or not they shall be submitted for hearing as provided in 13.033 and shall participate in such hearings as provided in 13.0341.

The Judicial Committee shall have authority to receive appeals from applicants who allege that they have been unfairly denied membership in the Society as provided in 3.33, to make such investigations as it deems necessary to determine the facts, and to report with recommendations to the Board of Trustees.

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CHAPTER 13 • Grievance Review and Impeachment

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13.03 Removal of Trustees

13.031 Jurisdiction

The Board of Trustees shall have sole and exclusive power to remove any elected trustee ~~or alternate trustee~~. Removal must be for cause, and the process for removal set forth in 13.03 shall be conducted in a confidential manner.

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13.034 Hearings
If the Judicial Committee recommends removal, a special meeting of the Board of Trustees to hear the case shall be convened within 45 days following transmittal of the recommendation by the Judicial Committee to the Board of Trustees. The President shall preside over the hearing.

13.0341 Conduct of Hearing
The hearing shall be under rules of procedure as determined by the Board of Trustees and copies of these rules shall be made available to all parties concerned.

The Board of Trustees may employ legal counsel.

The chair of the Judicial Committee or a member of the committee designated by the chair shall present the committee's recommendation.

~~Both t~~The trustee ~~or alternate~~ whose removal has been recommended and the Judicial Committee shall have the right to be represented by legal counsel.

13.035 Decision
Voting shall be by secret ballot, and a three-fourths (3/4) majority of the trustees ~~(or alternates)~~ present and voting shall be required for removal.

CHAPTER 14 • Meetings

14.01 Site
All meetings of the Society and of the House of Delegates shall be held within the Commonwealth of Massachusetts in such places as determined by the President, President-elect and ~~Vice~~ Immediate Past President in consultation with the Speaker and Vice Speaker.

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14.03 Annual Oration
There shall be an annual oration delivered by a member of the Society. The Orator shall be selected by the President, President-elect and ~~Vice~~ Immediate Past President, subject to confirmation by the Board of Trustees. The Society will seek agreement and consent of the Orator to record and transcribe the Annual Oration. If the Orator provides such consent, the Society shall create and preserve electronic recordings and written transcriptions of all Annual Orations as a permanent record of research and historical value.

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That the House of Delegates approve the proposed membership dues for calendar year 2024. 5/13/23

Physicians:	Current: 2023	Proposed: 2024
Introductory:	$200	$200
Family *(per person)*:	$400	$450
Regular *(second year and beyond)*:	$400	$450
Community Health Center based:	$150	$200
Military:	*Current member price of NEJM**	
** Dues are exempt if on active military duty*		
Out-of-state:	$175	$175
Life Membership	*Calculated based on age*	
Senior	$0	$100

**Change to Senior dues will require bylaws change at A23. Senior members will be dues exempt at age 80 and older.*

Residents: One-year resident membership: Three-year resident membership: *Renewable for the length of training* Out-of-state resident membership: Residency / Fellowship Programs: *With 100% participation* Medical Students: Multi-year Membership: Pre-paid enrollment for 2 years: Pre-paid enrollment for 3 years: Pre-paid enrollment for 5 years: Pre-paid enrollment for 10 years: Group Enrollment: Groups with 75% to 79% participation: Groups with 80% to 89% participation: Groups with 90% to 99% participation: Groups with 100% participation *Additional rates may apply for large group enrollments following Board of Trustee approved guidelines.*	\$60 \$150 \$60 *Free* *Free* *5% discount* *10% discount* *20% discount* *30% discount* *5% discount* *10% discount* *20% discount* *30% discount*	\$60 \$150 \$60 *Free* *Free*	
That the MMS amend the *Procedures of the House of Delegates,* Section 18, General Limits on Debate, so that each speaker shall be limited to two minutes. *(D)*			5/13/23
That the MMS sunset the standing Committee on Communications effective end of FY23. *(D)* That the MMS establish a new "Advisory Group on Communications" appointed by the President. *(D)*			5/13/23

APPENDIX B: Directives to Sunset upon Completion (Time-Limited/Specific or Pending Bylaw Amendment or Ratification at Annual Meeting of the Society)

Topic Area	Adopted
MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND MANAGEMENT Board of Trustees/Officers (Secretary-Treasurer position)	12/9/23
MMS ADMINISTRATION AND MANAGEMENT Diversity, Equity, and Inclusion	5/21/22
MASSACHUSETTS MEDICAL SOCIETY ADMINISTRATION AND MANAGEMENT Board of Trustees/Officers District Medical Societies (DLC)	5/13/23
PUBLIC HEALTH Law Enforcement/Justice System (AMA portion)	5/13/23

Award	Established	Renewal	Previously

		Review Schedule	Reviewed
MMS Lifetime Achievement	10/93	**2024**	2000 2017
Men's Health	5/09	**2024**	2017
Community Clinician of the Year	11/98	**2024**	2005 2017
Senior Volunteer Physicians	11/01 reaffirmed 5/09	**2024**	2017
Excellence in Medical Service	5/95	**2025**	2002 2018
Information Technology in Medicine	6/99	**2025**	2018
Grant V. Rodkey, MD, Award for Outstanding Contributions to Medical Education	1995	**2025**	2018
Distinguished Service to the MMS	5/95	**2026**	2002 2019
Woman Physician Leadership	5/12	**2026**	2019
Woman's Health	5/12	**2026**	2019
Medical Student Scholars	5/00 | reaffirmed 5/07 | amended/reaffirmed 5/12	**2026**	2019
Henry Ingersoll Bowditch Award for Excellence in Public Health	5/96	**2027**	2003 2020
LGBTQ Health	5/13	**2027**	2020

Woman's Health Research	5/13	**2027**	2020
Barbara A. Rockett, MD Early Career Physician Leadership Award	3/20	**2027**	
Reducing Health Disparities	5/14	**2028**	2021
Medical Student Essay Contest	5/07 | amended & reaffirmed 5/14 | amended 2018	**2028**	2021
Underrepresented Physicians of Tomorrow Award	4/21	**2028**	
Joseph M. Heyman, MD Award for Outstanding Contributions to Organized Medicine	1/22	**2029**	

Sunsetted Awards:

Oliver Wendell Holmes, MD, Stethoscope	11/99 11/06 5/13 Sunset 5/20		