## Reference Committee A — Public Health

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Whereas, The Massachusetts Medical Society (MMS) strategic priorities for 2017–2020 include promoting the integration of public health, behavioral health, and the social determinants of health; and

Whereas, The MMS strategic priorities for 2017–2018 include ensuring the Society is a productive and credible voice for physicians and patients at the state and federal level...” and providing “a leadership voice through its advocacy, collaboration, and public health efforts...; and

Whereas, The MMS has an extensive history of promoting public health through accident and violence prevention addressing varied public health concerns from helmets and mouth guards to impaired driving and firearm violence reduction; and

Whereas, The MMS currently supports the following two firearm safety policies, “reducing the number of deaths, disabilities, and injuries attributable to guns” and “encouraging health care providers to review gun safety as a routine component of preventive care”;1 and

Whereas, The MMS already supports the prohibition of firearm ownership by convicted felons and spouse and child abusers (Amended and Reaffirmed MMS House of Delegates, 5/19/12); and

Whereas, The Commonwealth’s strong gun safety laws have yielded significant results,2 including a gun-related mortality of 3.4 per 100,000 compared to the national average of 11.8 per 100,000;3 and

1Massachusetts Medical Society Policies, 2018


Whereas, Extreme Risk Protection Orders (ERPOs) are civil court orders issued by a judge after consideration of evidence from the petitions of various entities such as a family member, health care provider, or law enforcement officer. ERPOs are a formal legal process to temporarily withdraw an individual's access to firearms and ammunitions if the court determines that the individual poses a danger to themselves or others. ERPO laws provide liability protections to those who choose not to pursue an ERPO; and

Whereas, ERPOs have been implemented in some form in 5 states (Connecticut, Indiana, California, Oregon, and Washington), while 30 other states are considering such bills in a national effort; and

Whereas, In Connecticut, for every 10–20 firearm interventions, 1 life has been saved; and

Whereas, In the Commonwealth, The Duty to Warn Law poses a legal obligation of a clinician (specifically mental health professionals) to take reasonable precautions such as disclosure of information about an individual if there is an explicit threat to kill or inflict serious bodily injury upon reasonably identified persons and the individual has apparent intent and ability to implement the threat. It is incumbent on a clinician to balance ethical responsibility to protect their patient confidentiality with a legal obligation of reporting threats and harm reduction; and

Whereas, Currently, in the Commonwealth, there is no statute in place for ERPOs. Local police chiefs have the authority to suspend or repeal an individual's gun permit, but not previously purchased guns. No law exists at this time that imparts due process for the suspension of an individual's permit; rather, the determination is based solely on the authority of the local police chief, with significant variation across the Commonwealth; and

Whereas, ERPO legislation offers a solution to provide due process and a coordinated court proceeding, similar to that of the restraining order process in Massachusetts, that can serve to ensure the rights of the patient when a report has been made of a threat of violence; and,

https://www.kff.org/other/state-indicator/firearms-death-rate-per-100000/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

6 California Penal Code Part 6, Title 2, Division 3.2, Chapter 1, 18100-18205; https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=PEN&division=3.2.&title=2.&part=6.&chapter=1.&article=.
12 Massachusetts General Law Part I, Title XVII, Chapter 123 § 36B.
13 Massachusetts General Law Part I, Title XX, Chapter 140 § 131.
Whereas, Two Extreme Risk Protection Order bills are pending favorable report from the
Massachusetts Joint Committee on the Judiciary\textsuperscript{14,15}; therefore, be it

1. RESOLVED, That the MMS advocate to appropriate State and Federal policymakers
for Extreme Risk Protection Order policies that establish a civil-court mediated due
process by which access to and purchase of firearms may be temporarily withheld
from individuals who are deemed an imminent danger to themselves or others; and,
be it further \((D)\)

2. RESOLVED, That the MMS advocate for Extreme Risk Protection Order preventive
procedures (that establish a civil-court mediated due process by which access to and
purchase of firearms may be temporarily withheld from individuals who are deemed
an imminent danger to themselves or others) that do not alter the current legal
liability and standard by which health care providers are required to report if a person
is an imminent danger to themselves or others, thereby preserving current provider-
patient relationship expectations. \((D)\)

Fiscal Note: No Significant Impact

(Out-of-Pocket Expenses)

FTE: Existing Staff

(Staff Effort to Complete Project)

\textsuperscript{14} MA Bill H. 3081, 2018, \url{https://malegislature.gov/Bills/190/H3081}.
\textsuperscript{15} MA Bill H. 3610, 2018, \url{https://malegislature.gov/Bills/190/H3610}. 
Whereas, An MMS strategic priority is to “Ensure that the Society is a productive and credible voice for physicians and patients at the state and federal level, as well as local and national health care organizations” and to “provide a leadership voice through its advocacy, collaboration, and public health efforts”; and

Whereas, The MMS has the following relevant policy which pledges to reduce gun violence and supports this topic:

Handguns

Public Policy
1. The Massachusetts Medical Society supports the continued prohibiting of handgun sales to or transport by persons under the age of 21.
2. The Massachusetts Medical Society supports penalties for adults who leave guns accessible to children under the age of 18.

Education
1. The Massachusetts Medical Society supports the education of physicians about the epidemic of gun 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.
3. The Massachusetts Medical Society supports efforts to educate licensed firearms dealers on the health implications of firearm injuries and violence.

Collaboration
9. The Massachusetts Medical Society supports adding two new categories of prohibited buyers — spouse and child abusers.
10. The Massachusetts Medical Society supports prohibiting handgun possession by persons under the age of 18.

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

; and
Whereas, Gun violence is a major public health problem, resulting in over 200 deaths annually from intentional homicides and suicides in MA;¹ and

Whereas, Nationally among children and youth under 19 in 2015, more than 70 percent of all homicide deaths and over 40 percent of suicide deaths were the result of a firearm, and most firearm-related injuries and deaths of children and adolescents involve a handgun;² and

Whereas, The rate of gun deaths and injuries in MA and other states with strict licensing regulations and background check requirements is lower than that of states with lax rules. In fact, Massachusetts has the lowest rate of gun-related deaths in the country at 3.4 deaths per 100,000 population in 2016 according to the CDC;³ and

Whereas, Federal legislation to permit “concealed carry reciprocity” across state lines would lower standards across the country to the lowest common denominator by requiring all states to recognize concealed carry permits granted by other states and by allowing citizens with concealed carry permits in one state to carry guns into states that have stricter laws;⁴ and

Whereas, Attorneys General from 16 states and the District of Columbia as well as law enforcement officials across the nation have opposed “concealed carry reciprocity” because of the danger it poses to law enforcement agents, to victims of domestic violence, and to the public;⁵,⁶ and

Whereas, Twelve states have no requirements for background checks, firearms training, or a proven need to carry a weapon⁷ and, according to the Guns to Carry website, 14 states allow “permitless carry”;⁸ and

Whereas, MMS policy supports universal licensing requirements and background checks for firearm sales and encourages the AMA to support the same;⁹ and

Whereas, The MMS has committed to work to diminish gun violence in the US; therefore, be it

1. RESOLVED, That the MMS opposes 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; and, be it further (D)

2. RESOLVED, That the MMS, in the interest of safety for all citizens, encourage the AMA to oppose “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)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)
Whereas, MMS strategic priorities include a leadership voice in patient advocacy and addressing barriers that impede access to quality care; and

Whereas, The MMS and the AMA have the following policies on this topic:

**ABORTION**

The Massachusetts Medical Society adopts the AMA Policy on abortion which reads:

The AMA reaffirms its opposition to legislative proposals that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

*AMA: Reaffirmed I-93, Reaffirmed A-05, Reaffirmed, A-15, Reaffirmed I-93, Reaffirmed A-05, Reaffirmed A-15*

Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state and (2) Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

*AMA: Reaffirmed I-96, Reaffirmed: A-97 Reaffirmed I-00, Reaffirmed I-96, Reaffirmed A-97 Reaffirmed I-00)*

MMS Council, 10/11/89

Reaffirmed MMS House of Delegates, 5/7/99

Reaffirmed MMS House of Delegates, 5/12/06

Reaffirmed MMS House of Delegates, 5/11/13

; and

Whereas, Barriers to abortion care are widespread and multifactorial, including but not limited to: lack of access to clinics or providers, limited clinic capacity, the need for multiple appointments, state-imposed waiting periods, lack of insurance coverage, cost, gestational age limits, parental notification laws, stigma, and misinformation;¹ and

Whereas, Anti-abortion protesters employ tactics to intimidate, shame, and violate the privacy of women who present for reproductive health services, which further inhibits access to care;¹ and

Whereas, From the beginning of 2011 through July 2016, states enacted 334 new legal restrictions on abortion, further limiting access to abortion care. In 2018 alone, 695 provisions have already been introduced to further restrict abortion;² and

Whereas, These barriers are some of the many factors that cause patients to consider self-induced abortion. In 2015, there were more than 700,000 google searches for information regarding self-induced abortion in the United States, suggesting that many patients consider this option. National studies of abortion patients have shown that approximately 2% of patients attempted to self-induce an abortion at some point in their lives. That number is higher in states such as Texas with stricter legal restrictions on abortion, where one study showed that 7% of patients attempted some method to end their pregnancy before presenting to the clinic;³ and

Whereas, Laws criminalizing self-induced abortion increase health risks and deter patients from seeking necessary health care services related to self-induced abortion or miscarriage;⁴ and

Whereas, Laws criminalizing patients who self-induce abortion lead to increased suspicion towards patients presenting to health care providers for miscarriage;⁵ and

Whereas, People of color are disproportionately targeted for prosecution and criminalization related to pregnancy outcomes;⁶ and

Whereas, The Academy of Obstetricians and Gynecologists (ACOG) has taken a very strong position that patients should not be prosecuted for trying to end their own pregnancies and opposes forcing physicians to share information about patients due to its burdensome interference in the patient-provider relationship;⁷ and

Whereas, The ability and willingness to access medical care if complications relating to self-induced abortion arise is essential for patient safety;⁸ and

³ https://www.guttmacher.org/united-states/abortion.
⁶ Ibid.
Whereas, The criminalization of self-induced abortion does not help to address underlying societal and public health issues, nor does it benefit women’s health; and

Whereas, The reproductive decision-making within the context of race, class, and income status is experienced uniquely by all women and, particularly, women of color who are more likely to be targeted for prosecution and investigation of self-induced abortion due to disproportionate law enforcement of African American communities in general, and

Whereas, Fear of prosecution and potential incarceration undermines public health endorsement of open communication with primary care providers as well as promotion of early feto-maternal care; therefore be it,

1. RESOLVED, That the MMS will advocate against any legislative efforts or laws in Massachusetts or federally to criminalize self-induced abortion; and, be it further (D)

2. RESOLVED, That the MMS encourage the MMS AMA Delegation to submit a resolution to the AMA stating that the AMA will advocate against any legislative efforts or laws to criminalize self-induced abortion. (HP)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)


Whereas, Involuntary civil commitment is defined by law as the commitment of a person who is ill, incompetent, drug-addicted, or the like, without the consent of the person being committed; and

Whereas, In response to the opioid crisis, the scope of these laws has rapidly expanded, as the number of states with such laws went from 18 in 1991 to 38 jurisdictions and counting;¹ and

Whereas, Existing data on both the short- and long-term outcomes following involuntary civil commitment for reasons related to substance-use disorder does not support its broad utilization,² including recent data suggesting coercive treatment puts patients at higher risk of fatal overdose;³ and

Whereas, Current Massachusetts state law⁴ authorizes the state to involuntarily civilly commit someone with an alcohol or substance-use disorder for up to 90 days; and

Whereas, The legal standards and procedures for involuntary civil commitment in Massachusetts are very broad and allow for the presiding judge to over-rule the clinical determination of the commitment’s appropriateness; and

Whereas, Massachusetts Governor Charlie Baker introduced “An Act Relative to Combatting Addiction, Accessing Treatment, Reducing Prescriptions, and Enhancing Prevention” (CARE Act),⁵ which proposes to expand involuntary civil commitment in Massachusetts to include a second, short-term civil commitment option without judicial involvement; and

Whereas, Involuntary civil commitment of persons for reasons related to substance-use disorder has already been implicated in a number of human rights abuses and suicides in Massachusetts;⁶ and

¹ http://www.namsdl.org/IssuesandEvents/NEW%20Involuntary%20Commitment%20for%20Individuals%20with%20a%20Substance%20Use%20Disorder%20or%20Alcoholism%20August%202016%2009092016.pdf
² http://jaapl.org/content/43/3/313.long
⁴ Section 35 of Massachusetts General Law chapter 123
Whereas, Some contend Governor Baker’s proposal is part of a misguided national
trend to use involuntary civil commitment or other coercive treatment mechanisms to
address the country’s opioid crisis; and

Whereas, Massachusetts’s own mandated evaluation of overdose data has found that
people who were involuntarily committed were more than twice as likely to experience a
fatal overdose as those who completed voluntary treatment;⁷ and

Whereas, MMS strategic priorities include providing a leadership voice through...
advocacy, collaboration, and public health efforts and developing resources and tools
on... opioid use, misuse, dependence and abuse; and

Whereas, The MMS has no policy on this topic; therefore, be it

1. RESOLVED, That the MMS advocate to limit the practice of involuntary civil
commitment for reasons related to substance-use disorder in Massachusetts
and nationally in furtherance of health, ethical, and patient rights imperatives;
and, be it further (D)

2. RESOLVED, That the MMS oppose further expansions of authority to
involuntarily civilly committed persons for reasons related to substance-use
disorder in Massachusetts and nationally; and, be it further (D)

3. RESOLVED, That the MMS work to advance policy and programmatic efforts to
address gaps in voluntary substance-use treatment services; and, be it further
(D)

4. RESOLVED, That the MMS advocate that the American Medical Association
work to limit, and oppose further expansions of authority in, the practice of
involuntary civil commitment of persons for reasons related to substance-use
disorder; and be it further (D)

5. RESOLVED, That the MMS advocate that the American Medical Association
work to advance policy and programmatic efforts to address gaps in voluntary
substance-use treatment services. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Whereas, MMS strategic priorities are to provide a leadership voice through its advocacy, collaboration, and public health efforts and to work toward improved patient care and outcomes; and

Whereas, The MMS has no policy on this topic; and

Whereas, Under Massachusetts state law a judge may forcibly commit to treatment any person with reasons related to substance-use disorder who is deemed a danger to themselves or others;¹ and

Whereas, Massachusetts is the only state that places persons involuntarily civilly committed for reasons related to substance-use disorder into the care of the penal system;² and

Whereas, Massachusetts state law was amended in 2016 to require that women involuntarily civilly committed for reasons related to substance-use disorder be treated at facilities licensed by the state Department of Public Health or Department of Mental Health;³ and

Whereas, Current Massachusetts state law, adopted in 2016, reads “the person may be committed to: (i) a secure facility for women approved by the department of public health or the department of mental health, if a female; or (ii) the Massachusetts correctional institution at Bridgewater, if a male;” creating a clear difference in the settings of care extended to men and women; and

Whereas, The facility at Bridgewater has since been replaced for this use by the Massachusetts Alcohol and Substance Abuse Center (MASAC) at a minimum-security correctional facility at Plymouth run by the Department of Corrections; and

Whereas, The Boston Globe has described conditions at the Plymouth MASAC facility as “a mere jail,” and describes unsanitary conditions, poor treatment of mental health problems, and abusive corrections officers;⁴ and

¹ M.G.L ch.123 §35.
³ M.G.L ch.123 §35
⁴ Ibid Cramer and Freyer.
Whereas, One inmate suicide and multiple attempted suicides have been reported at the facility within its first half-year of operation; and

Whereas, The burden of requiring that the state Department of Public Health or the Department of Mental Health approve of specific facilities and treatment programs for persons involuntarily civilly committed for reasons related to substance-use disorder is a relatively small one; and

Whereas, Effective and humane treatment of persons involuntarily civilly committed for reasons related to substance-use disorder is of urgent importance in the current opioid crisis in Massachusetts; and

Whereas, The MMS, as the representative of physicians in Massachusetts, ought to play a role in shaping the treatment of persons with substance-use disorders in any facility in the state; therefore, be it

1. RESOLVED, That the MMS 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 programs approved by the same; and, be it further (D)

2. RESOLVED, That the MMS 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 standards of care. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)

Whereas, MMS strategic priorities include providing a leadership voice through... advocacy, collaboration, and public health efforts... and developing resources and tools on... opioid use, misuse, dependence, and abuse; and

Whereas, The MMS has as Our Mission...“to do all things as may be necessary and appropriate ...to promote medical institutions formed on liberal principles for the health, benefit and welfare of the citizens of the Commonwealth”; and

Whereas, Unintentional overdose deaths of American citizens caused by non-prescribed opioids in 2016 exceeded 60,000 as a result of the desired heroin being either laced with fentanyl or replaced entirely with fentanyl, a more powerful opioid than heroin; and

Whereas, Quality control is unknown in the “black market” so customers are at the mercy of dealers who themselves may be ignorant of the ingredients being sold as heroin; and

Whereas, Those addicted to heroin are afraid to come forward for treatment because they fear arrest for possession under current laws; and

Whereas, The numbers of deaths attributed to unintentional overdoses of opioids plummeted after Portugal decriminalized possession of opioids in 2001 and arranged for treatment options for those addicted;¹ and

Whereas, In order to justify full legalization one must establish clearly that every citizen currently has a right to use and possess dangerous yet legal substances which they might inhale, ingest, imbibe, snort, or inject, such as dangerous drugs often used in suicide attempts, e.g., acetaminophen (Tylenol), which is available without prescription in any pharmacy; tobacco smoked freely despite it being responsible for emphysema and causes deaths of hundreds of thousands of people each year in the US; and alcohol used widely, once prohibited by Constitutional Amendment, repealed 14 years later, and still responsible for tens of thousands of deaths annually in the US;² and

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(Jeffrey Miron is the director of economic studies at the CATO Institute and a senior lecturer and director of undergraduate studies in the department of economics at Harvard University)

Whereas, It remains the position of the MMS that we do not recommend use of any drugs which are potentially harmful, such as nicotine or opioids, for non-therapeutic purposes; and

Whereas, Our advocacy of legalization should not be misconstrued as encouragement for these drugs to be used recreationally. Instead we understand that users who avail themselves of these drugs — opioids in particular — through the black market, risk that they will receive stronger dosages or drugs laced with or replaced in full by far stronger and more potent drugs such as fentanyl, which are known to cause respiratory suppression and death; therefore, be it

1. RESOLVED, That the MMS advocate for the repeal of state laws that make possession of small amounts of illicit opioids, such as heroin and fentanyl, a criminal offense and instead urge public policy to promote the offering of treatment options; and, be it further (D)

2. RESOLVED, That the MMS advocate to state and federal legislators to repeal laws or regulations which prohibit the possession, distribution, or use of illicit opioids, due to the lethality of these variable, unpredictable, unregulated substances, such as fentanyl and heroin, bought in the black market. (D)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)
Item #: 7
Title: Capital Punishment Policy
Sponsor: Committee on Ethics, Grievances, and Professional Standards
Ronald Arky, MD, Chair

Referred to: Reference Committee A
Marian Craighill, MD, MPH, Chair

Background
At I-06, the House of Delegates adopted the following policy, which was most recently reaffirmed at A-13:

Capital Punishment

The Massachusetts Medical Society adopts the American Medical Association Council on Ethical and Judicial Affairs Opinion E-2.06, “Capital Punishment,” adopted in June 2000, with the exclusion of the provision of the opinion regarding organ donation by prisoners, to read as follows:

An individual’s opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure, monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial,
testifying as to medical aspects of aggravating or mitigating circumstances during
the penalty phase of a capital case, or testifying as to medical diagnoses as they
relate to the legal assessment of competence for execution; (2) certifying death,
provided that the condemned has been declared dead by another person; (3)
witnessing an execution in a totally nonprofessional capacity; (4) witnessing an
execution at the specific voluntary request of the condemned person, provided
that the physician observes the execution in a nonprofessional capacity; and (5)
relieving the acute suffering of a condemned person while awaiting execution,
including providing tranquilizers at the specific voluntary request of the
condemned person to help relieve pain or anxiety in anticipation of the execution.

Physicians should not determine legal competence to be executed. A physician’s
medical opinion should be merely one aspect of the information taken into
account by a legal decision maker such as a judge or hearing officer. When a
condemned prisoner has been declared incompetent to be executed, physicians
should not treat the prisoner for the purpose of restoring competence unless a
commutation order is issued before treatment begins. The task of reevaluating
the prisoner should be performed by an independent physician examiner. If the
incompetent prisoner is undergoing extreme suffering as a result of psychosis or
any other illness, medical intervention intended to mitigate the level of suffering is
ethically permissible. No physician should be compelled to participate in the
process of establishing a prisoner’s competence or be involved with treatment of
an incompetent, condemned prisoner if such activity is contrary to the physician’s
personal beliefs. Under those circumstances, physicians should be permitted to
transfer care of the prisoner to another physician. (HP)

MMS House of Delegates, 11/04/06
Reaffirmed MMS House of Delegates, 5/11/13

Relevance to MMS Strategic Priorities
MMS’s Capital Punishment policy supports the MMS’s strategic priority on physician and
patient advocacy. Having policy that clearly defines physicians’ roles with regard to legal
executions allows the MMS to provide a leadership voice through its advocacy when the
issue arises at the state or national level.

Discussion
At A-14, the House of Delegates adopted OMSS Report A-14 A-103, Review of
Positions on Medical Ethics, which requires the MMS to monitor the statements related
to medical ethics adopted by the American Medical Association (AMA) and other
sources periodically, as events and circumstances demand.

As directed by OMSS Report A-14 A-103, Review of Positions on Medical Ethics, the
Committee on Ethics, Grievances, and Professional Standards (EGPS) monitors
statements related to medical ethics adopted by the AMA and other sources. On June
13, 2016, the AMA completed its first comprehensive update to the AMA Code of
Medical Ethics in more than 50 years. According to the AMA, this update was
undertaken to improve the code’s (1) relevance (by ensuring that the language applies to
contemporary medical practice), (2) clarity (by improving structure and formatting to
ensure that foundational ethical principles and specific physician responsibilities are
easy to find, read and apply), and (3) consistency (by consolidating related issues into a
single, comprehensive statement).
In 2006, the MMS adopted the CEJA Opinion E-2.06 *Capital Punishment*, with the exclusion of the provision of the opinion regarding organ donation by prisoners. The current version of the AMA’s Code of Medical Ethics includes an updated policy on Capital Punishment (CEJA Opinion 9.7.3). The updated CEJA Opinion adds language regarding the treatment of incompetent condemned prisoners, but is otherwise substantively similar to the opinion it replaced.

Conclusion

EGPS voted at its October 11, 2017, meeting to recommend adoption of the CEJA Opinion 9.7.3 *Capital Punishment*, with the exclusion of the provision of the opinion regarding organ donation by prisoners, to replace the MMS’s current policy on capital punishment.

Recommendation:

That the Massachusetts Medical Society adopt-in-lieu of the Capital Punishment policy adopted at I-13 and reaffirmed at A-13 the following:

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)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses) Existing Staff (Staff Effort to Complete Project)
Whereas: The Massachusetts Medical Society (MMS) 2017–18 Strategic Priorities state that the MMS shall “Provide a leadership voice through its advocacy, collaboration, and public health efforts”; and

Whereas, Currently the MMS has no policy regarding the health impacts of neonicotinoids, a widely used pesticide in the United States; and

Whereas, American Medical Association (AMA) Policy states:

Pollution Control and Environmental Health H-135.996

Our AMA supports (1) efforts to alert the American people to health hazards of environmental pollution and the need for research and control measures in this area; and (2) its present activities in Pollution Control and Environmental Health H-135.996

; and

Whereas, According to the United States Geological Survey (the sole science agency for the Department of the US Interior), neonicotinoids, agricultural pesticides linked to the deaths of bee colonies and the most commonly used pesticides today on the American market, were developed in the 1990s to replace organophosphates;¹ and

Whereas, Neonicotinoids, chemically similar to nicotine bind to the nicotine acetylcholine receptor, leading to disorientation, paralysis, and death within a few hours in the target species;² and

Whereas, Since the acetylcholine receptor is found in many species, these chemicals are producing unintended health effects in non-target species;³,⁴,⁵ and

¹ Pesticide National Synthesis Project of National Water-Quality Assessment Program (USGS).
Whereas, Since neonicotinoids are used to treat seeds prior to planting; they infiltrate every part of the growing plant and fruit; importantly for humans. The pesticide residue cannot be washed away with water;\textsuperscript{6,7} and

Whereas, Because neonicotinoids are highly water soluble and only two percent of the pesticide is absorbed by crops, their use has led to widespread contamination of the soil, surface water, deep aquifers,\textsuperscript{7} and drinking water\textsuperscript{8} and persist in the environment both in Massachusetts and worldwide; and

Whereas, Neonicotinoids are found in 86 percent of US honey, as well as in fruits, vegetables, and infant formula, often at levels over the regulatory limit;\textsuperscript{9} and

Whereas, These neurotoxins are not selective for insects responsible for crop blights but also kill beneficial insects, such as honeybees, where the link to colony collapse disorder has now been decisively shown; and are leading to declines in other species such as bats, birds, and earthworms;\textsuperscript{10345} and

Whereas, The $15 billion US agricultural sector depends on pollinators\textsuperscript{11}; insect pollination is integral to food security in the United States; bees are essential to the production of at least 90 commercially grown crops in North America and 87 of the leading 115 crops globally (35 percent of global food production);\textsuperscript{11} and

Whereas, The number of managed honeybee colonies has declined precipitously from 6 million colonies in 1947 to 2.5 million today; given the heavy dependence of certain crops on commercial pollination, reduced honeybee populations present an immense threat to domestic agriculture. This threat to pollinators, represents, implicitly, a threat to our food supply;\textsuperscript{11} and

Whereas, Because humans, birds, invertebrates, and fish are exposed through inhalation or ingestion via air, pollen, food, or water, the effects of these chemicals have implications for all species;\textsuperscript{12} and

\textsuperscript{10} “EPA: Neonicotinoid Pesticides Pose Serious Risks to Birds, Aquatic Life.” EcoWatch, 18 Dec. 2017
\textsuperscript{11} “Fact Sheet: The Economic Challenge Posed by Declining Pollinator Populations.” National Archives and Records Administration, National Archives and Records Administration, 20 June 2014
\textsuperscript{12} Michelle L. Hladik, Dana W. Kolpin, Kathryn M. Kuivila, Widespread occurrence of neonicotinoid insecticides in streams in a high corn and soybean producing region, USA, Environmental Pollution, Volume 193, 2014, Pages 189-196, ISSN 0269-7491, \url{https://doi.org/10.1016/j.envpol.2014.06.033}. 
Whereas, Acute exposure in humans is reported to cause tremor, short term memory loss, slurred speech, and prolonged QT interval, among other side effects;\(^\text{13}\) and

Whereas, Because neonicotinoids are neurotoxins,\(^\text{13}\) there is concern that in humans this may translate to an increased risk of central nervous system disorders (i.e., Parkinson’s disease, Alzheimer’s disease, schizophrenia, and depression), alterations to the developing brain, and reproductive and developmental effects;\(^\text{14}\) and

Whereas, In addition to being neurotoxic, these persistent chemicals are endocrine disruptors and have been demonstrated to lead to hyperthyroidism in mouse models;\(^\text{15}\) and

Whereas, These chemicals are carcinogenic and mutagenic to mammalian cells\(^\text{16}\); and hepatotoxic and hepatocarcinogenic in mice;\(^\text{17}\) and

Whereas, Neonicotinoids are associated with decreased fertility in animal models\(^\text{18,19}\) and with birth defects in humans; in the San Joaquin valley where these pesticides are used extensively, studies show an association with cardiac birth defects such as Tetralogy of Fallot;\(^\text{20}\) and

Whereas, Based on the body of scientific evidence, the European Commission banned three neonicotinoid insecticides in 2013 and expanded this ban to include all five neonicotinoids in January 2018; the European Food Safety Authority (EFSA) cited evidence that neonicotinoids “may adversely affect the development of neurons and brain structures associated with learning and memory”;\(^\text{21}\) and

Whereas, Other organizations advocating for a ban include the Canadian Association of Physicians for the Environment and the Registered Nurses of Ontario;\(^\text{22}\) and

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\(^\text{17}\) Swenson TL. "Neonicotinoid Insecticide Metabolism and Mechanisms of Toxicity in Mammals." University of California, Berkeley, UCB Libraries, Apr. 9, 2013.


\(^\text{22}\) “Doctors, Nurses Urge Ontario to Ban Neonicotinoids.” CBC Business News, Canadian Broadcasting Company, 17 Nov. 2014,
Whereas, Quebec has recently imposed a ban on five common pesticides: atrazine, chlorpyrifos, and three neonicotinoids (clothianidin, imidacloprid, and thiamethoxam) (Feb 19, 2018); and

Whereas, Maryland is the first state in the US to adopt a ban on use of neonicotinoid pesticides (Jan 1, 2018); and

Whereas, Representatives Earl Blumenauer (OR-03) and Jim McGovern (MA-02) introduced the *Saving America’s Pollinators Act* in early 2018 to protect the health of critical pollinators, such as honeybees, and urges the EPA to fully investigate the effect of harmful pesticides on bees; therefore, be it

1. RESOLVED, That the MMS advocate for non-hazardous alternatives to neonicotinoids, such as those used in Europe since 2013, including but not limited to: biopesticides, integrated pest management, and eco-engineering; and, be it further (D)

2. RESOLVED, That the MMS advocate for passage of legislation in Massachusetts to regulate the use of neonicotinoids in Massachusetts due to the direct and indirect public health effects. (D)

Fiscal Note: No Significant Impact (Out-of-Pocket Expenses)

FTE: Existing Staff (Staff Effort to Complete Project)

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MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 9
Code: Resolution A-18 A-108
Title: Gaming Addiction Now a Mental Health Disorder
Sponsor: Ihor Bilyk, MD

Referred to: Reference Committee A
Marian Craighill, MD, MPH, Chair

Whereas, An MMS strategic priority is to work toward improved patient care and outcomes; and

Whereas, The MMS has no policy on the topic of gaming addiction or disorder; and

Whereas, The World Health Organization (WHO) is adding “gaming disorder” to the 11th edition of its International Classification of Diseases, known as ICD-11 (scheduled for publication in mid-2018); and

Whereas, The WHO defines gaming disorder as “a pattern of gaming behavior ('digital-gaming' or 'video-gaming') characterized by impaired control over gaming, increasing priority given to gaming over other activities to the extent that gaming takes precedence over other interests and daily activities, and continuation or escalation of gaming despite the occurrence of negative consequences”; 1 and

Whereas, A diagnosis of gaming disorder is based on behavior that causes “significant impairment in personal, family, social, educational, occupational, or other important areas of functioning and would normally have been evident for at least 12 months”; and

Whereas, Gaming disorder commonly affects the young and male population; adults may be affected as well and the disorder may occur in up to 15% of the general population.2 Gaming disorder can cause significant harm to people’s lives and may include social isolation, poor sleep habits, a decline in school grades, or dropping out of school entirely, with possible overlap with attention deficit disorder, anxiety, and depression;3 and

Whereas, Sometimes when the pathological addictive state of gaming disorder may be difficult to differentiate from somewhat excessive but otherwise normal recreational activity of gaming, a mental health professional or a specialist in addiction psychiatry may need to be consulted for proper diagnosis; therefore, be it

1. RESOLVED, That the MMS will advocate and educate regarding the adverse public health effects of gaming disorder as a service to our legislators and other parties interested in objective and factual data; and, be it further (D)

1 www.who.int/features/qa/gaming-disorder/en
3 Ibid.
2. RESOLVED, That the MMS encourage physicians to advise their patients and parents of their patients of the addictive potential of gaming; and, be it further

(D)

3. RESOLVED, That the MMS encourage physicians to advise specific prevention measures that parents can use for their children, which may include monitoring what and how much their children play video games, keeping the gaming activity in a public place to allow better control, setting up rules, and limiting where gaming devices are kept and the times they are used (for example, no gaming two hours before bedtime and only after chores and homework are done). (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Whereas, An MMS strategic priority is to work toward improved patient care and outcomes; and

Whereas, The MMS has a general policy on child abuse, sexual harassment/misconduct, and sexual assault (see appendix), but it does not address the specific situation of child abuse occurring within the fashion industry; and

Whereas, Sexual exploitation and abuse of men and women of all ages in many industries have been recently reported on a frequent basis in the news; and

Whereas, There have been many instances of abuse and exploitation of children of both sexes under 18 years of age as expressed by the victims within the fashion industry as described in a recent article in the *Boston Globe*;¹ and

Whereas, A sampling of some of the repulsive behaviors include the following: groping and fondling of the models by the photographer; a photographer masturbating in front of a model while threatening to ruin their family if they told anyone; agents providing drugs and alcohol to child models; withholding earnings and coercing models into sexual relationships as teenagers; failing to inform models that photo shoots would require nudity; encouraging models to sleep with photographers to advance their careers; models being sent to sets with known predators; sexual misconduct by agents, stylists, casting directors, and other industry professionals which include violations ranging from unwanted kissing to rape; and models being told not to tell anyone of their abuses because complaining about the perpetrator would hurt the model’s chances of making it big;² therefore, be it

1. **RESOLVED,** That the MMS will advocate to the AMA, requesting exploration of ways to increase the physicians’ and public’s awareness of the potential for child sexual exploitation and abuse within the fashion industry; and, be it further *(D)*

2. **RESOLVED,** That the MMS discuss with legislators about how to further study and possibly prevent the potential for child sexual exploitation and abuse within the fashion industry, as published in recent news outlets. In particular, issues that may be addressed with legislators may include the possibility of providing legal protections and reform of the youth-obsessed fashion industry to include basic safeguards such as private dressing rooms, if not currently


² Ibid.
available (so models don’t have to get naked in public); to require the presence of a parent/guardian and an additional non–industry-related adult on the set at all photo shoots, if not currently available (to prevent having the underage model alone in the room with a photographer or other industry professional); and to require having a work contract, if not currently available, to include a parent/guardian and the underage model that details exactly what type of photo shoot would be done and whether any nudity would be involved. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
Appendix

CHILDREN

Abuse and Neglect

The Massachusetts Medical Society will continue to support initiatives to increase physicians', other health workers', and the public's knowledge of child abuse to improve education and training methods for the prevention, diagnosis, and treatment of child abuse; 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 abuse. (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

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 abuse problem; in improving education and training in the use of existing resources and methods for the prevention, diagnosis, and treatment of child abuse; in promoting the development of 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

ETHICS

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

Sexual Assault

The Massachusetts Medical Society (MMS) affirms its commitment to addressing and preventing sexual assault. (HP)

The MMS supports the development of physician educational programs and resources, as well as patient education materials, pertaining to sexual assault. (HP)

The MMS strongly encourages and facilitates the participation of physicians, physicians-in-training, and medical students in educational programs that address sexual assault. (HP)

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Items 2 and 3: Reaffirmed MMS House of Delegates, 5/17/14
Item 1 of 3: Amended and Reaffirmed MMS House of Delegates, 5/17/14
Background

“Infant mortality is the best indicator of the health and well-being of a community or state, because the same biological, social, economic, and environmental risk factors that contribute to infant health also affect the health of the broader population.”\(^1\) Although Massachusetts had the third lowest infant mortality rate in the country (3.9 deaths per thousand live births compared to a rate of 5.8 nationally as of 2016),\(^2\) this low rate is not equally distributed across counties. Low-income communities and communities of color tend to have much higher infant mortality rates with rates varying geographically according to the most recent data available (see Table 1).\(^3\)

<table>
<thead>
<tr>
<th>Table 1: Select Infant Mortality Rates in Massachusetts by City, 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infant Mortality Rate</strong></td>
</tr>
<tr>
<td>Massachusetts Overall</td>
</tr>
<tr>
<td>Fitchburg</td>
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<tr>
<td>Chelsea</td>
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<tr>
<td>Worcester</td>
</tr>
</tbody>
</table>

*Infant Mortality Rate: Number of infant deaths per 1,000 live births

Source: Massachusetts Department of Public Health. 2017 State Health Assessment.

Findings in Table 2 demonstrate that rates of infant mortality among blacks were more than two times that of whites, while Hispanic infant mortality rates were 1.5 times higher than whites geographically according to the most recent data available.\(^4\)

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4 Ibid.
Table 2: Select Infant Mortality Rates in Massachusetts by Race/Ethnicity, 2014

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Infant Mortality Rate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic Black</td>
<td>7.3</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>5.0</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>3.4</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>2.9</td>
</tr>
</tbody>
</table>

*Infant Mortality Rate: Number of infant deaths per 1,000 live births based on linked birth and death records.
Source: Massachusetts Department of Public Health. 2017 State Health Assessment.

One way to identify and help address the issue of unequal rates of fetal and infant death is via Fetal Infant Mortality Reviews (FIMRs), a public health multi-part process that supplements state birth records with detailed information from individual record reviews by medical professionals and in-home interviews with mothers about their experiences. “Currently there are 200 FIMR programs conducted in 40 states and have proven to be beneficial. For example, one FIMR program saw deaths of infants under four months of age from pertussis. That FIMR program responded by offering Tdap vaccines to family members of pregnant women to minimize potential exposure to pertussis.”

Currently the Massachusetts Department of Public Health oversees monitoring of fetal and infant deaths in the state using the following process:

1. Death occurs
2. Death certificates issued to local probate registrar
3. No notification to local public health entities with the exception of Sudden Unexpected Infant Death (SUID) or Sudden Infant Death Syndrome (SIDS) currently occurs

The following steps are conducted in an FIMR process:

1. Death occurs
2. Massachusetts Dept. Public Health (DPH) notifies approved local public health departments within time period determined by DPH
   - Notification would include information determined by the DPH. Likely to be included are:
     - Hospital/location of death
     - Details of death
     - Mother’s identity and contact information
3. Cases to be reviewed are identified
4. Hospital charts reviewed to determine cause of death
5. Mother is contacted and asked to be interviewed
6. Case record created by combining medical information and mother’s interview

7 Ibid.
Clinical Review Team (CRT) reviews case record
  - for medical, system, and cultural opportunities for prevention and make recommendations
- Community Action Team (CAT) take community actions based on opportunities identified by CRT
- Ability to improved health outcomes

The National FIMR Program estimates costs to implement FIMR for local health organizations at $400–$700 per FIMR while infrastructure costs will vary based on current personnel at local public health entities.8

Although some hospitals conduct chart reviews on fetal and infant deaths in Massachusetts, no Massachusetts communities are conducting processes aligned with FIMR guidelines.9 Therefore, Massachusetts legislators have sponsored a bill, H.1219, An act to establish fetal and infant mortality review10, seeking to establish an FIMR in Massachusetts under the direction of the Massachusetts Department of Public Health (DPH). H.1219 would direct the DPH to notify local public health organizations of an infant’s death in a timely manner. The process is voluntary in that H.1219 authorizes, not requires, local public health to conduct FIMR should they desire. Passage of bill would require the DPH to establish a process and criteria for local public health entities to become “FIMR approved.” Approved communities would then have access to vital statistics data and other information, such as physician and hospital records, required for the FIMR process.

With the passage of the FIMR bill, the DPH would need to notify the local public health entity of all individual infant deaths in a timely manner. Without such notification it is often difficult for the local public health entities who wish to conduct FIMR to do so. Core to the FIMR review is the family member interview which is typically with the mother. This is a unique element to the review that brings voice to the personal experience of the death and provides important insights to uncover actionable opportunities to improve health outcomes.11

The Worcester Healthy Baby Collaborative, a volunteer group of community agencies and health care organizations working to reduce disparities in Worcester's infant mortality rate (IMR), described the important role an FIMR would serve in addressing health inequities associated with fetal and infant deaths in that city:

“Here in Worcester, where our volunteer public health physicians do real time chart reviews allowing us to be ahead of the state data, Worcester's IMR in the three-year period 2013–2015 is 5–6 per thousand live births with our Hispanic infant mortality above 10 per thousand live births in the same time period. We have struggled for over 20 years to consider the potential causes of the disparities in Worcester's IMR. We have always wanted more timely data and

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8 Boston Public Health Commission. An Act to Establish Fetal Infant Mortality Review (FIMR) H.1219
9 Ibid.
more opportunity to dig deeper into the individual stories in a timely way that, if
performed sensitively and professionally, will add richness to our understanding
of the factors related to infant loss through the voices that comes directly from
grieving families, not through the filter of medical chart audits.”\textsuperscript{12}

Boston embarked on an FIMR process twice in the past with short-term grant-funded
programs. Although both ended with loss of funding and relied primarily on a review of
burial permit applications no longer possible given changes in regulations, these efforts
yielded useful insights.\textsuperscript{13} According to the Boston Public Health Commission, “Allowing
Massachusetts communities to carry out FIMR processes in line with best practices will
bring new insight, helping us lower the mortality rate in communities whose rates now
exceed the state average.”\textsuperscript{14} The FIMR includes a community engagement process
whereby the maternal voice and community voice are heard as well as a process where
the social determinants of health are also considered.\textsuperscript{15}

Current MMS Policy
The MMS does not have current policy on the monitoring or review of infant mortality in
the Commonwealth.

Relevance to MMS Strategic Priorities
An MMS strategic priority is physician and patient advocacy as the FIMR seeks to
monitor the impact of the rapidly transforming health care landscape on Massachusetts
physicians and patients. The MMS also seeks to improve patient care and outcomes.
Lastly, the FIMR is important to the MMS’s priority to play a leadership role in developing
a sustainable health care delivery system by promoting the integration of public health,
behavioral health, and the social determinants of health across physician practices.

Discussion
The FIMR is important as it highlights the service gaps and system breakdowns that can
occur in the areas of fetal and infant health while monitoring emerging birth outcome
trends in an effort to proactively bring about system change and improve the quality of
health care in the Commonwealth. Currently, no such mechanism or process is in place
in Massachusetts. Without one, it is unlikely that the Commonwealth will be able to
uncover and address the systemic causes and social determinants of health factors
impacting unequal rates of fetal and infant death that vary by geography, race/ethnicity,
and socioeconomic factors across Massachusetts.

\textsuperscript{12} Worcester Healthy Baby Collaborative. Shields SG, Chair. Letter to the Massachusetts Joint
Committee on Public Health in support of H. 1219, An Act Relative to Conducting Fetal and Infant
\textsuperscript{13} Allen D. Bringing FIMR to Massachusetts. Worcester Infant Mortality Summit. September 22,
2017.
\textsuperscript{14} Boston Public Health Commission. An Act Relative to Conducting Fetal and Infant Mortality
Review (FIMR). 2018
\textsuperscript{15} Allen D. Bringing FIMR to Massachusetts. Worcester Infant Mortality Summit. September 22,
2017.
Conclusion
The Committee on Maternal and Perinatal Welfare (CMPW) supports the introduction of a timely, voluntary, systematic FIMR process for Massachusetts in order to address health inequities. To that end, the CMPW proposes the following recommendations.

Recommendations:
1. That the MMS supports the timely, voluntary, systematic monitoring of fetal and infant mortality in Massachusetts. (HP)

2. That the MMS will work with the appropriate stakeholders, regulators, and/or policymakers to advocate for the establishment of a timely, voluntary, systematic monitoring of fetal and infant mortality in Massachusetts. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)
MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 12
Title: Ensuring Oral Health as a Component of Accountable Care Organizations
Sponsors: Committee on Oral Health
Hugh Silk, MD, Chair
Michelle Dalal, MD

Referred to: Reference Committee A
Marian Craighill, MD, MPH, Chair

Background
Oral health is essential to overall health. While periodontal disease is largely preventable, it remains the most common chronic disease in the United States. As they do with physical and behavioral health services, all patients should also have access to patient-centered, integrated, and continuous quality oral health care.

Current Relevant MMS Policy
While the MMS has much policy on accountable care organizations (ACOs), the first listed below is the only one relevant to this report.

ACCOUNTABLE CARE ORGANIZATIONS
That 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.

…

Oral Health

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

Relevance to MMS Strategic Priorities

An MMS strategic priority is to play a leadership role in developing a sustainable model of health care delivery by promoting the integration of public health, behavioral health, and the social determinants of health across physician practices.

Further, a relevant MMS strategic priority is to provide a leadership voice through its advocacy, collaboration, and public health efforts, and will continue to carefully monitor the impact of the rapidly transforming health care landscape on Massachusetts physicians and patient.

Discussion

Data from current national and state health care reform efforts strongly suggest that integrating oral health into primary care delivery improves patient outcomes and lowers overall health care costs. In fact, evidence available from commercial insurers such as United Concordia and Kaiser Permanente have shown remarkable results, particularly for patients with chronic diseases, such as coronary heart disease and diabetes, who received dental treatment and maintenance.

The Medicaid program in Massachusetts, known as MassHealth, launched an ACO program on March 1, 2018, to restructure MassHealth to be more patient-centered, integrated, accountable, and value-driven over the next five years. This program presents a tremendous opportunity to elevate oral health through the health care system more broadly as well as improve the way that oral health care is financed and delivered. Importantly, an oral health quality measure has been approved by the Centers for Medicare and Medicaid Services (CMS) to be


included in the ACO quality measure slate for which all 17 ACOs will be held accountable to meet during each year of the ACO program. The inclusion of this quality measure establishes a formal incentive for primary care providers in the ACOs to obtain training on oral health to better understand the oral health needs of their patients and to build structured bi-directional, closed-loop referral networks with community-based dental providers.

Conclusion
Integrating dental services back into the rest of the health care system incentivizes medical and dental providers to communicate with each other to provide effective care coordination in areas such as pain and/or chronic disease care management. Improving interprofessional collaboration encourages patients to seek community-based dental treatment to appropriately address their oral health needs without turning to hospital emergency departments and/or opioid use to manage dental pain.

Recommendations:
1. That the MMS collaborate with and advocate to appropriate stakeholders for comprehensive integration of oral health services into all Accountable Care Organization models in Massachusetts. (D)
2. That the MMS support the development of oral health quality metrics for Accountable Care Organization models. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
FTE: Existing Staff
(Staff Effort to Complete Project)
One in 10 people in Massachusetts are food insecure\(^1\), which is defined as “a household-level economic and social condition of limited or uncertain access to adequate food.”\(^2\) The Massachusetts Medical Society (MMS) has consistently supported full funding for the Supplemental Nutrition Assistance Program (SNAP) and is on the Massachusetts Food is Medicine State Plan Initiative,\(^3\) which addresses food insecurity as a health issue and seeks to improve access to food and nutrition services. The MMS can further its commitment to this issue by adopting a food insecurity screening policy.

Current MMS Policy
The MMS has no policy on food insecurity screenings in clinical settings.

Relevance to MMS Strategic Priorities
MMS strategic priorities include physician and patient advocacy to improve patient care and outcomes, and sustainable health care delivery by integrating public health, behavioral health, and the social determinants of health across physician practices.

Discussion
Poor nutrition has been associated with negative health outcomes across age groups: children, adults, and seniors. Consumption of unhealthy foods, such as sweets and processed meats, is associated with weight gain and increased risk of diet-related chronic disease. Further, economical processed foods that are energy dense and nutrient poor can contribute to the double burden of malnutrition. Consumption of healthy foods, such as fruits and vegetables, is associated with weight reduction and decreased risk of diet-related chronic disease.\(^4,5,6\)

Food insecurity is associated with inadequate nutrition and is also associated with poor health in children, adults, and seniors. In adults, food insecurity is associated with

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increased risk for diseases and conditions like diabetes, hypertension, and depression. In children, food insecurity is associated with increased risk for impaired brain development, hospitalizations, iron-deficiency anemia, mental health and behavioral disorders.⁷,⁸,⁹,¹⁰,¹¹

Food insecurity is also associated with great economic costs to the state of Massachusetts. A recent study conducted by Children’s Health Watch estimated the health-related costs of food insecurity and hunger in Massachusetts to be at least $2.4 billion in the year 2016.¹² Despite its clinical significance, preliminary research indicates that routine screenings for food insecurity by health providers are as low as 12.7 percent in some areas.¹³

A validated and efficient food insecurity screening tool, the Hunger Vital Sign™,¹⁴ identifies individuals and families as being at risk for food insecurity if they answer that either or both of the following two statements is ‘often true’ or ‘sometimes true’ (vs. ‘never true’):

1. “Within the past 12 months we worried whether our food would run out before we got money to buy more.”
2. “Within the past 12 months the food we bought just didn’t last and we didn’t have money to get more.”

The significance of addressing food insecurity is supported by several medical organizations. For example, the American Medical Association (AMA) approved a program to support “improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity.”¹⁵ Additionally, many other organizations support food insecurity screening and intervening, such as the American Academy of Pediatrics (AAP), which recommends screening for “food insecurity at scheduled health maintenance visits or sooner”¹⁶, the Nutrition and Obesity Network Policy Research and Evaluation (NOPREN), which created an algorithm for conducting food insecurity screenings on adults and recommends screening all adult patients at least once and screening high-

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risk patients annually,\textsuperscript{17} and Healthy People 2020, whose objectives include to “eliminate very low food security among children” and to “reduce household food insecurity and in doing so reduce hunger.”\textsuperscript{18}

**Conclusion**

Food insecurity presents a significant health and financial burden in Massachusetts. Physicians and health care providers can help address this problem by screening patients in health care settings and referring food insecure patients to appropriate resources.

**Recommendations:**

1. The MMS recommends routine food insecurity screening by health care providers using the Hunger Vital Sign\textsuperscript{TM}, a screening tool that can identify individuals and families as being at risk for food insecurity. \textit{(HP)}

2. 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. \textit{(HP)}

3. The MMS will communicate its policy regarding support for routine food insecurity screenings in all clinical settings to appropriate Massachusetts organizations, including, but not limited to: the Massachusetts Public Health Association, Massachusetts Association of Health Boards, Massachusetts Board of Allied Health Professionals, Massachusetts Board of Nursing, Massachusetts Department of Public Health, Massachusetts Health Council, Massachusetts Health and Hospital Association, and the Massachusetts League of Community Health Centers. \textit{(HP)}

**Fiscal Note:** No Significant Impact \textit{(Out-of-Pocket Expenses)}

**FTE:** Existing Staff \textit{(Staff Effort to Complete Project)}


MASSACHUSETTS MEDICAL SOCIETY HOUSE OF DELEGATES

Item #: 14
Title: Streamlining Human Immunodeficiency Virus Testing of Source Patients following an Occupational Exposure
Sponsors: Committee on Public Health
Steven Ringer, MD, Chair
Committee on Legislation
Theodore Calianos, MD, Chair
MA AMA Delegation
Alain Chaoui, MD, FAAFP, Chair
Organized Medical Staff Section
Frank Carbone Jr., MD, Chair

Report History: Resolution: A-17 A-103
Original Sponsors: Brandon Wojcik, MD, Jennifer Singleton, MD, and Resident and Fellow Section

Referred to: Reference Committee A
Marian Craighill, MD, MPH, Chair

Background
At A-17, the House of Delegates (HOD) referred Resolution A-17 A-103, Streamlining Human Immunodeficiency Virus Testing of Source Patients Following an Occupational Exposure, to the Board of Trustees (BOT) for report back with recommendations at A-18. The BOT referred items 1 and 2 to the Committee on Public Health in consultation with the Committee on Environmental and Occupational Health and Organized Medical Staff Section, and item 3 to the Committee on Legislation, MA AMA Delegation, and Organized Medical Staff Section. The resolution states the following:

1. That the MMS work with appropriate organizations to promote hospital adoption of admission and procedural consent documents that inform the patient that undisclosed HIV testing will be performed in the event of an occupational exposure and results will only be released with further counseling and written consent, with report back of hospital implementation at A-18. (D)

2. That the MMS supports HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids. (HP)

3. That the MMS work with appropriate organizations, including the AMA, to draft and promote the adoption of legislation and hospital staff guidelines to allow HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids with report back at A-18. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)
Reference Committee Testimony

At A-17, the reference committee recommended that this resolution/report be Referred for Report Back at A-18. The following is the reference committee’s rationale:

Your reference committee heard testimony both online and in person that was largely supportive of the concept of amending laws and policies to promote HIV testing upon exposure to protect the health of health care workers and patients. As testimony progressed, several fundamental questions were raised about this resolution indicating that, while incredibly important, this issue is more complex than it may first appear. Testimony raised legal and ethical questions such as how to handle HIV testing in the absence of patient consent, and about the variability of the 36 other state laws referenced in the resolution.

There remained confusion about the intent of “undisclosed HIV testing” in Resolved 1, leading to disparate interpretations about whether this implied a lack of disclosure to the patient, to the health care worker, or to the institution. Testimony also indicated substantial variability of relevant hospital policy in Massachusetts, indicating confusion even about settled Massachusetts laws. Additionally, testimony highlighted the need to protect patients who may be exposed by health care workers, and to expand the policy to all health care facilities and not just hospitals.

Ultimately, in recognizing the importance and complexity of this issue, your reference committee recommends that this resolution be referred to the Board of Trustees for report back at A-18.

Current MMS Policy

The MMS has the following policy:

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. (HP)

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. (HP)

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

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

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.

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

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

Relevance to MMS Strategic Priorities
The resolution relates to the MMS strategic priority of physician and patient advocacy: advocate to improve the physician practice environment and work toward improved patient care and outcomes.
Discussion
The Committee on Environmental and Occupational Health and the Committee on Public Health reviewed MMS policy and Massachusetts Law related to HIV testing and informed consent, the original resolution, and the reference committee report. Additionally, the committee spoke with the sponsors of the original resolution, reviewed policies of the AMA and other professional associations, and was in touch with the state department of public health, hospital/health system attorneys, and patient advocacy organizations for input. The Committee on Legislation, the MA AMA Delegation and the OMSS also discussed the resolution.

The MA AMA Delegation met on September 5, 2017, and reviewed item #3 as directed. “That the MMS work with appropriate organizations, including the AMA, to draft and promote the adoption of legislation and hospital staff guidelines to allow HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids with report back at A-18.”

Following a lengthy discussion, the delegation agreed that there is sufficient AMA policy and a CEJA Opinion regarding this topic and voted for no further action. Specific policies include: HIV/AIDS Reporting, Confidentiality, and Notification H-20.915 and Code of Medical Ethics Opinion 8.1 specifically item (d).

MMS Government Relations staff continues to monitor relevant HIV laws in Massachusetts.

HIV in Massachusetts
There are an estimated 26–27,000 residents living with HIV/AIDS in Massachusetts, including approximately 21,000 people with known HIV. Deaths in people with HIV/AIDS, and progression of HIV infection to AIDS, have been declining significantly. New HIV diagnoses decreased by about half from 2000 to 2014, which the state attributes to its prevention and care infrastructure. Most infections result from sexual activity.¹

Occupational exposures in health care facilities
The risk of occupational exposure is relatively very low. The Massachusetts Department of Public Health (MDPH) receives reports of every test indicative of HIV infection among Massachusetts residents and follows up on all newly diagnosed infections. The last occupational HIV infection the MDPH identified based on HIV reports in health care workers and on direct reports from health care workers was in 1998, resulting from an injury from a needle sticking out of a sharps container, with unknown source patient.

For HIV transmission to occur, the exposure must include both infectious body fluid and percutaneous, mucous membrane, or cutaneous entry with non-intact skin. When the source is HIV positive, percutaneous exposure have been shown to carry an average 0.23% risk of transmission, mucous membrane 0.09%; cutaneous exposure with non-intact skin 0.09%.² Factors that might increase health care worker risk for HIV infection include exposure to a larger quantity of blood from the source, for example, if a device was visibly contaminated with the patient’s blood, and was placed directly in a vein or artery, or a deep injury. Risk was also increased for exposure to blood from source persons with terminal

illness. The most recent study of health care worker percutaneous or mucous
exposures to HIV, published in 2016, found 0% seroconversion.

Approximately 3100 percutaneous injuries are reported by hospitals each year to the
Massachusetts Sharps Injury Surveillance System (MSISS). After eight years of decline, the
number of sharps injuries has remained steady since 2010. The most recent MSISS report
suggests that many of these injuries may have been prevented with the use of available
sharps injury prevention features (37%), improved training and product design (45%),
improved disposal practices (49%), and safer work practices in operating and procedure
rooms.

The US Preventive Health Service Guidelines recommend occupational management of HIV
risk through “(1) primary prevention of occupational exposures; prompt management of
occupational exposures and, if indicated, initiation of PEP [post-exposure prophylaxis] as
soon as possible after exposure; (3) selection of PEP regimens that have the fewest side
effects and that are best tolerated by prophylaxis recipients; (4) anticipating and
preemptively treating side effects commonly associated with taking antiretroviral drugs; (5)
attention to potential interactions involving both drugs that could be included in HIV PEP
regimens and other medications that PEP recipients might be taking; (6) consultation with
experts on post-exposure management strategies (especially determining whether an
exposure has actually occurred and selecting HIV PEP regimens, particularly when the
source patient is antiretroviral treatment experienced); (7) HIV testing of source patients
(without delaying PEP initiation in the exposed provider) using methods that produce rapid
results; and (8) counseling and follow-up of exposed HCP.”

Post-exposure prophylaxis (PEP) is generally recommended when an exposure is known to
be HIV positive or at high risk of being HIV positive. However, in cases of unknown status,
PEP is generally not warranted.

Concerns have been noted that sources may test negative for HIV, but may be in a
“window,” a period of weeks after infection but before detectable HIV antibodies develop,
and should therefore still take PEP. However, according to the USPTF, no cases of
occupational transmission have been reported in the United States when a source has

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3 Kuhar DT, Henderson DK, Struble KA, et al. Updated US Public Health Service guidelines for the
management of occupational exposures to human immunodeficiency virus and recommendations for
postexposure prophylaxis. *Infection Control and Hospital Epidemiology.* 2013; 34(9): 875–892.

HIV contaminated body fluids: The University of Pittsburgh 13-year experience. *American Journal of

5 Davis LK, DeMaria A. Sharps Injuries among Hospital Workers in Massachusetts (Rep).

6 Kuhar DT, Henderson DK, Struble KA, et al. Updated US Public Health Service guidelines for the
management of occupational exposures to human immunodeficiency virus and recommendations for
postexposure prophylaxis. *Infection Control and Hospital Epidemiology.* 2013; 34(9): 875–892.

7 PEP quick guide for occupational exposures. Published January 1, 2018.
http://nccc.ucsf.edu/clinical-resources/pep-resources/pep-quick-guide.

www.acep.org/Physician-Resources/Clinical/Hematologic/Post-Exposure-Prophylaxis-for-Bloodborne-
Pathogens/#sm.0000s5ggbtqfgezes1v1xmb7rdu9l. Published June 2009.
tested negative during this window, and PEP is not recommended if the source tests negative.\textsuperscript{9} Sharps exposures can be a distressing experience regardless of disease transmission occurring; counseling may be recommended for the exposed health care worker.\textsuperscript{10,11}

**Testing of patients for HIV**

Where HIV status is unknown, in addition to reducing anxiety and informing the need for PEP in the exposed individual if the source tests negative for HIV, HIV testing can benefit source patients. In 2013, the US Preventive Services Task Force issued recommendations for the screening of adolescents and adults aged 15 to 65 years for HIV infection, and for younger and older people who are at increased risk.\textsuperscript{12,13} For patients who do not know their HIV status, testing can lead to knowledge of status, and, if positive, referral to treatment.

Most source patients (estimated to be 95% or more) who are asked give consent to testing for HIV in the event of an occupational exposure. Communication strategies and best practices can be employed to increase the likelihood of a patient’s consent.

Other cases where consent cannot be obtained include an incapacitated or an unknown source patient. In cases where the patient is incapacitated and unable to give consent, a valid health care proxy may be invoked, or temporary guardianship may be sought to obtain consent.\textsuperscript{14}

In rare instances, source patients refuse to consent to be tested. A patient’s reasons for refusing consent to HIV testing may include fear, misinformation about HIV, mistrust in the medical community, cultural barriers, concerns about personal or relationship consequences, or fear of HIV status being recorded in health care or public health..\textsuperscript{15,16}

While some may feel HIV is no longer stigmatized in health care, and exceptional policies should not be employed, reports show stigma remains. Massachusetts advocacy groups and case managers indicate stigma and discrimination persist in the community and in health care; individuals with HIV have experienced negative consequences in the workplace, in housing, in health care, and in personal relationships. Nearly 8 in 10


Americans being treated for HIV experience internalized stigma around HIV. Stigma associated with HIV can prevent individuals from receiving proper health care, reduce chances of beginning treatment, and be complicated with the compounded elements of stigma associated with substance use, mental health, or sexual orientation.

There are currently 35 states that have laws allowing for some kind of unconsented HIV testing following an occupational exposure.

The Massachusetts Department of Public Health does not support testing of patients without their knowledge of being tested and the result, and without consent. Patient advocates have historically opposed attempts at mandated testing, including of patients, health care workers, people who are arrested, and prisoners.

Historically, there has been strong opposition from the patient advocacy groups to weakening of Massachusetts laws to mandate testing without consent in the case of occupational exposures.

Informed Consent in Massachusetts

Massachusetts law requires informed consent prior to testing for HIV. There is a longstanding common law right in Massachusetts for patients to receive informed consent. A 1982 case in the Supreme Judicial Court in Massachusetts clarified, "A physician owes a duty to his patient to disclose in a reasonable manner all significant medical information that the physician possesses or reasonably should possess that is material to the patient’s informed judgment whether to give or withhold consent to a medical or surgical procedure, and the physician’s failure to make a disclosure constitutes professional misconduct.” Failure to provide informed consent can lead to malpractice liability in certain circumstances.

There are exceptions to this requirement to obtain informed consent, such as rendering emergency care to an incapacitated patient. In addition, there are balancing tests to determine which types of information are material and need to be required in the informed consent process. In fact, in the 1982 case, the Supreme Judicial Court added, “The patient’s right to know must be harmonized with the recognition that an undue burden should not be placed on the physician.”

Broadly speaking, there is no specific legal mandate about how informed consent must be obtained. For many simple procedures, simply having a conversation about the risks, benefits, alternatives, and a confirmation of consent is sufficient.

Informed Consent for HIV Testing

In Massachusetts, certain types of medical information require, by statute, specific mechanisms for obtaining informed consent. HIV testing has long been subject to exceptional laws regarding informed consent. For many years, Massachusetts required informed written consent for HIV testing and disclosure. However, in 2012, An Act Increasing Screening for HIV became law, as Chapter 84 of the Acts of 2012. The law now allows for verbal informed consent from the individual being tested.

The law states, “A facility, as defined in section 70E, physician or health care provider shall not (1) test any person for the presence of the HIV antibody or antigen without first obtaining

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that person's verbal informed consent; (2) disclose the results of such test to any person
other than the subject of the test without first obtaining the subject's written informed
consent; or (3) identify the subject of such tests to any person without first obtaining the
subject's written informed consent. A written consent form shall state the purpose for which
the information is being requested and shall be distinguished from written consent for the
release of any other medical information."

Currently, Massachusetts law permits a patient to provide verbal informed consent to be
tested for HIV.

However, the confidentiality protections for disclosing the results of a person's HIV test and
identifying a person as the subject of an HIV test remain the same, requiring written
informed consent. The law clearly mandates written informed consent be obtained prior to
disclosing the results of a person's HIV test, or prior to identifying a person as a subject of
an HIV test. Therefore, without written consent, the results of the source's test results could
not be revealed to the exposed health care worker.

The same law later notes that a general consent to provide medical treatment that may be
obtained upon presentation or admission to a hospital, for example, would not be sufficient
to comply with the law. However, if such a form were amended to include a very specific,
separate section to address HIV testing consent, this would be considered sufficient to
comply with the law.

Possible Changes to Massachusetts Law

The first means by which Massachusetts law could be amended would be to strike the
requirement that written informed consent be obtained prior to releasing results of HIV laws.

However, following discussions with different legal counsel at Massachusetts hospitals and
health systems, if state law were amended to remove the requirement of separate written
consent for HIV testing and disclosure, there would not necessarily be a change to the
practical approach of hospitals and physicians who wish to perform an HIV test upon
occupational exposure. Because of the highly charged history and sensitive nature of an
HIV test, counsel indicated that it is likely that hospitals would continue to elect to obtain
specific, likely written, informed consent about HIV testing upon occupational exposure.
Ideally this language would be included in a form to be reviewed and signed by a patient at
admission.

The second means by which Massachusetts could amend its laws would be to allow for the
HIV testing of a patient without his or her consent. This approach, taken in various forms by
dozens of other states, could allow for hospitals and physicians to avoid the process of
obtaining informed consent. This approach raises a host of ethical concerns.

Ethical issues

This issue is a balance of the rights of an exposed health care provider, or anyone exposed
to potentially infectious bodily fluids, to the information to best develop a post-exposure
treatment plan his or her care with the autonomy and rights of the source patient to informed
consent or refusal to procedures on his or her body, and to privacy and confidentiality of his
or her medical information.

Informed consent is both an ethical and legal principle that is crucial to the physician-patient
relationship.

Health care workers are not the only individuals who may be potentially exposed. Patients
and visitors may be exposed to potentially infectious fluids from other patients or from their
health care workers. The MMS and the AMA oppose the mandatory release of health care
workers HIV status, or other disease status, to patients, though some patient groups have advocated for this information. The concept of recommending a policy for the benefit of one category of people (health care workers) at the expense of another category of people (patients) appears self-serving and hypocritical.

Testing without the source patient’s consent creates further ethical and procedural dilemmas with regard to informing the source patient of test results, particularly in the case of positive test results.

Additionally, testing without informed consent jeopardizes the physician-patient relationship, and the credibility of the profession as an advocate for patients. The MMS’s Code of Ethics, reaffirmed in May 2016, states, in relevant part, “A physician shall, while caring for a patient, regard responsibility to the patient as paramount.”

Removing the requirement of informed consent will not solve all cases of unknown HIV status. The source may be unknown or may have left the premises at the time of the exposure. And individuals, such as janitorial staff, first responders, and the public, may be exposed to HIV within and outside of the health care setting.

Conclusion

Exposure to potential blood-borne pathogens can cause anxiety and/or unnecessary treatment and associated side effects and personal consequences. Knowledge of the HIV status of the source of the exposure can help reduce anxiety and inform treatment options. The committees recommend all efforts to support the exposed individual medically and emotionally, without compromising the principles of informed consent or the primacy of the physician’s responsibility to the patient.

Although sharps exposures in health care facilities are fairly common, the risk of contracting HIV from these exposures is low, with no known cases occurring from such an exposure in Massachusetts since 1998. Testing for HIV holds benefit for the source patient as well as the exposed worker. In nearly all cases, patients provide consent to testing; in rare cases patients refuse to provide consent. There are processes for obtaining consent from incapacitated patients, and communication and admissions strategies to increase the likelihood of obtaining consent from autonomous patients. Post-exposure prophylaxis started early is very effective. While PEP has significant side effects, it is generally recommended when the source’s HIV seropositivity is unknown if the source is at high risk.

Testing for and disclosure of HIV status without informed consent is illegal in Massachusetts. In the political climate in Massachusetts, an effort to change the state law is unlikely to succeed. Efforts to advocate for the rights of the health care worker over the rights of the patient may risk the MMS’s credibility among members and the public.

The mandatory testing of a patient in the absence of the patient’s prior informed consent, or contrary to the patient’s expressed wishes, runs counter to legal standards in Massachusetts, and puts physicians and facilities at risk for legal action.

More importantly, informed consent is a critical principle of medical care and of the primacy of the physician-patient relationship, which the MMS holds sacrosanct. Testing without informed consent, particularly for the benefit of someone other than the patient, contrary to the ethical principles of medicine. As stated in the MMS’s Code of Ethics, a physician’s responsibility to the patient is the physician’s paramount responsibility.

The committees would encourage that health care providers promote awareness of the benefits of HIV testing and encourage testing for HIV during routine patient visits; that health care facilities and agencies adopt policies and procedures in compliance with
Massachusetts law to facilitate informed consent to HIV testing in the event of an occupational exposure, and to prevent stigma for health care workers and patients related to HIV; that hospitals’ standard admission patient consent forms include a separate written consent to testing for HIV in the event of that of a sharps or other high-risk exposure by a hospital employee, and clearly state that the patient has the right to refuse or revoke permission at any time, and that such refusal or revocation will not jeopardize other aspects of care; that following source testing after an occupational exposure, the physician who ordered the test inform the source patient of the test result, and patients testing positive for HIV will be counseled by a knowledgeable nurse or physician; and that provisions be made for contacting source patients whose test results become available after discharge; that health care facilities make information and support available to health care workers about the risks, procedures, and available support available following occupational exposures to potentially infected bodily fluids; that health care facilities employ primary prevention strategies to prevent exposure from sharps; and that acute care hospitals report sharps injuries to the Massachusetts Sharps Injury Surveillance System.

In discussing these issues and principles internally, and with hospital representatives, patient advocacy groups, and others whom MMS policy might impact, the Committee on Public Health (CPH) recognized the many ethical and legal issues involved, and struggled to make recommendations that are practicable and without unintended negative consequences. The CPH will continue to work on this issue and monitor Massachusetts legislation.

The Organized Medical Staff Section understands and supports the CPH’s investigation and well-crafted report. The CPH and COL will continue to work with appropriate entities related to HIV testing laws and policies for the protection and benefit of Massachusetts health care workers and patients. The OMSS will continue to monitor these initiatives and provide input as needed.

Recommendation:

That the Massachusetts Medical Society not adopt Resolution A-17 A-103 which reads as follows:

1. That the MMS work with appropriate organizations to promote hospital adoption of admission and procedural consent documents that inform the patient that undisclosed HIV testing will be performed in the event of an occupational exposure and results will only be released with further counseling and written consent, with report back of hospital implementation at A-18. (D)

2. That the MMS support HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids. (HP)

3. That the MMS work with appropriate organizations, including the AMA, to draft and promote the adoption of legislation and hospital staff guidelines to allow HIV testing of a patient while maintaining privacy, but without mandated explicit consent, where a health care worker has been placed at risk by exposure to potentially infected body fluids with report back at A-18. (D)

Fiscal Note: No Significant Impact
(Out-of-Pocket Expenses)

FTE: Existing Staff
(Staff Effort to Complete Project)