Massachusetts Medical Society

MMS Policy Compendium

Massachusetts
Medical Society

MASSACHUSETTS MEDICAL SOCIETY
POLICY COMPENDIUM
(1978–2016)

FOREWORD

This edition of the *Massachusetts Medical Society Policy Compendium* presents the policy positions of the Society as of the close of business at the 2016 Interim Meeting of the House of Delegates.

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

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

Please be aware that those policies listed herein and acted upon at the 2016 Interim Meeting are unofficial until the House votes to approve the *Proceedings of the 2016 Interim Meeting*.

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

James Gessner, MD President	David Rosman, MD Speaker	Francis MacMillan Jr., MD Vice Speaker

/at

PURPOSES OF THE MASSACHUSETTS MEDICAL SOCIETY

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

— Section 2, Acts of Incorporation, 1781

As referenced in Bylaws, Chapter 1, 1.00

MMS Policy Compendium
Table of Contents

Abortion **1**
Accident Prevention **1**
Safety Belts 1
Acquired Immunodeficiency Syndrome (AIDS) **1**
Addiction **4**
Drug Addiction *(Please See Additional Policies under Reproductive Health)* 4
Gambling 4
Aging **5**
Long Term Care 5
Alcohol **5**
Allied Health Professions and Services **5**
OB/GYNs and Certified Nurse-Midwives 5
Physicians and Nurse Practitioners/Physician Assistants 5
Radiological Technologists 7
Scope of Practice 7
American Medical Association **7**
Partnership for Growth Agreement 7
awards **7**
Blood Donation **7**
Children and Youth **8**
Abuse and Neglect 8
Breastfeeding 8
Bullying 8
Child-Resistant Packaging *(Please See Additional Policy under Tobacco/Smoking & Drugs and Prescriptions)* 9
Epinephrine Supply 9
Safe Infant Sleep 9
Sugar Intake 9
Mental Health/Substance Abuse 9
Pediatric Screening Tests 10
Perinatal Quality Collaborative 10
Physical Education 10
Religious Exemptions 10
School Start Times 10
Special Health Care Needs 10
Civil and Human Rights **11**
Military/Medical Policies Affecting Transgender Individuals (Please also see policy under Public Health/ 11
Nondiscrimination *(Please Also See Policies under "Public Health, LGBT Patients/Matters")* 11
Non-Discrimination Statement 12
Torture 12
Communication **12**
Drugs and Prescriptions **13**
Biosimilar Medications 13

Child-Proof/Tamper-Proof Versions 13
Compounding Pharmacies 13
Copayments/Medications for Chronic Diseases 14
Direct-to-Consumer Advertising 14
Drug Formularies 14
Education Regarding Industry Marketing and Advertising 16
Generic Drugs 16
Limits on Medications and Testing or Treatment Supplies 16
Marijuana: Legalization 16
Marijuana: Medical Use of *(Please See Additional Policy under Reproductive Health)* 17
Marijuana: Recreational Use of *(Please See Additional Policy under Reproductive Health)* 18
Off-Label Uses 19
Opioids/Nasal Naloxone 19
Over-the-Counter Medications/Brand-Name Vs. Generic 19
Performance Enhancing Drugs 20
Personal Medication Lists 20
Prescription Marketing 20
Prescription Prices 20
Prescription Writing/E-Prescribing 21
Reduction of Illegal Drug Use 21
Return of Unused and/or Expired Medications 21
Sharing of Prescribing Data 22
Emergency Medical Services 22
CPR Programs/Public Access Defibrillation 22
Emergency Room Overcrowding 23
Environmental Health 23
Air Quality 23
Biodiversity 24
Biomass Plants 24
Chemical/Environmental Exposures 24
Climate Change 25
Fluoridation 25
Fossil Fuels 25
Mercury 25
Nuclear Energy 26
Water Filtration 26
Ethics 26
Billing and Collection Practices 26
Capital Punishment 27
Cloning 28
Confidentiality: Medical Student Physical Diagnosis 29
Confidentiality: Statement of Principles 29
Ethics and Managed Care 32
Finder's Fees 36
Genetic Information and Patient Privacy 36

Gifts to Physicians from Industry 38
Health Facility Ownership by Physicians 45
Medical Education/Performing Procedures 46
Medical Ethics 46
Notification of Physician Departure 47
Patenting of Medical and Surgical Procedures 48
Patient Testimonials 48
End-of-Life Care *(Please See Additional Policy under Medical Education)* 49
Referrals 50
Sale of Health-Related Products from Physicians' Offices 50
Sexual Harassment/Misconduct 51
Stem Cell Research – Federal Funding of 51
Firearms: Safety and Regulation 52
Assault Weapons 52
Handguns 52
Health Care Delivery 54
Accountable Care Organizations 54
Care for Military Casualties 58
Clinical Integration 58
Complementary and Alternative Medicine 59
Physician Services 59
Physician-Controlled Offices, Ambulatory Surgery Centers, and Free-Standing Imaging Centers 59
Scientifically Unproven Risks 61
Team-Based Health Care 61
Telemedicine 62
Treatment Variations 63
Workers' Compensation Coverage 63
Health Education 63
Student Health 63
Translation of Patient Education Material 63
Health Insurance/Managed Care Plans 63
Administrative Costs 63
Coverage Decisions 64
Financial Incentives 65
Health Insurance 66
Hospice Care/Benefits 67
HPV Vaccine 67
Informing Patients' Regarding Health Care Costs 68
Insurance Reform 68
Managed Care Resources & Education 68
Physician Budgets/Withholds 68
Radiology Co-Payments 68
Value-Based Insurance Design 69
Health System Reform 69
Fee-for-Service 71
Health Care Costs 71

Ideal Payer System 72
Massachusetts Health Reform Law 72
Patient Protection 73
Special Commission on the Health Payment System 73
Universal Access 73
Hospitals 74
Compensation/Physician Services 74
Credentialing 74
Hospital and Health Care Facility Closings 75
Hospitalists 76
Hospital Admissions 79
Hospital/Organized Medical Staff/Employed Physicians 80
Mergers or Conversions 85
Neonatal Outcomes and Care 86
Patient and Family Advisory Councils 87
Personal and Financial Information 88
Primary Care Physicians 88
Uniform Application 89
Uniform Standards for Non-Profits and For-Profits 89
Legal Medicine 89
Due Process 89
Massachusetts Medical Society Administration and Organization 90
Boston Medical Library 90
Budget 90
Charitable and Educational Fund 91
Committees/Sections 92
Committee on Senior Volunteer Physicians Health Center Program 92
Conflicts of Interest Policy 93
Cotting Luncheon 93
District Medical Societies 93
Grants-in-Aid 93
Historical Preservation 94
House of Delegates 94
Leadership Development/Ambassador Program 95
Leadership Development 96
MMS Leadership Initiative 96
Membership and Dues 96
Policy Resources and Tracking 98
Publishing Division 99
Sections 99
Strategic Direction 100
Volunteer Vouchers 102
Medicaid 102
Eligibility Criteria and Enrollment 102
MassHealth Program 102
Preauthorizations 102
Medical Education 103

Accreditation Council for Continuing Medical Education (ACCME) 103
Albert Schweitzer Fellowship Program 103
Care for Persons with Intellectual Disability/Developmental Disability 103
Continuing Medical Education Accreditation 103
Educational Debt 104
End-of-Life Care *(Please See Additional Policies under Ethics)* 104
Graduate Medical Education 105
LGBT Students and Patients 105
State-Funded Medical School 105
Medical Records/Electronic health records 106
Electronic Health Records 106
Medicare/Medicaid Services 110
Funding 110
MassHealth 110
Practice Expenses 110
Mental Health 110
Mental Health Services: Gestation and Postpartum 110
Mental Health Services Principles 110
Insurance Company Health Surveys 112
Minorities 113
Biomedical Sciences Career Project 113
Medical Interpreters 113
Minority and Immigrant Populations 113
Nurses and Nursing 114
Nursing Profession 114
Physician Payment 115
Capitation 115
Claims Processing 115
CPT Codes 115
Recoupment Limitations 116
Resource Based Relative Value Scale (RBRVS) 116
Third Party Insurers 117
Physicians 118
Collegiality 118
Definition of "Disruptive Physician Behavior" 118
Gender Parity 118
JC Standards 118
Peer Review 118
Principles on Medical Professional Review of Physicians 121
Workforce 128
Preauthorizations 129
Office Practice Expenses 129
Preauthorizations 129
Professional Liability 132
ERISA 132
Excess Professional Liability Insurance 132
Health Courts 132

Joint and Several Liability 132
Medical Staff Privileges 133
No-Fault Medical Liability Insurance 133
Participation in Health Insurance Plans 133
Personal Property Exemption 133
Physician Expert Witnesses 133
Tort Reform 134
Profiling, Tiering, and Physician Performance 135
Tiering 139
Public Health 141
Advance Directives/Health Care Proxy 141
Antibiotics/Agricultural Animals 141
Concussion 142
Emergency Preparedness 142
Fitness Trainer Certification 143
Full-Body Airport Scanners 143
Genetically Engineered Foods 143
Helmets 144
Human Medicine, Veterinary Medicine, and Environmental Sciences 144
Influenza Vaccination/Other Vaccinations *(Please See Additional Policy under Emergency Preparedness)* 145
LGBT Patients/Matters *(Please Also See Policies under "Civil/Human Rights, Nondiscrimination" and "Medical Education, LGBT Patients and Students")* 145
Marketing of Candy Containing Hemp Oil 147
Men's Health 147
Mouth Guards 147
Organ Donation 148
Performance Enhancing Drugs 148
Physical Activity/For Students 148
Pre-Hospital Stroke Protocol 148
Public Safety 148
Safe Eclipse Observation 149
State Funding for Disease Control Programs 149
State Laboratory 149
Public Relations 149
Reproductive Health 150
Emergency Contraception 150
Womens' Health Training 151
Quality of Care 151
Patient Safety 152
Quality Measurement/Quality Improvement 155
Risk Contracts 157
Sleep Medicine 158
Regulation and Licensure 158
Board of Registration in Medicine 158
Centralized Verification 158
Clinical Skills Assessment 159

"Meaningful Use" and Other Web-Based Mandates/Requirements 160
Research 161
Medical Research...161
Residents 161
Surgery 162
Ambulatory Surgery Centers 162
Laser Surgery...162
Outpatient Surgery 162
Robotic Surgery/Training 163
Standards of Care...163
Technology 163
Electronic Mail...163
Meaningful Use Requirements 163
Social Media 164
Technology in Health Care 165
Tobacco/ Smoking 165
Anti-Smoking Poster Contest 165
E-Cigarettes..165
Point-of-Sale Tobacco Advertising (*Please Also See Government Initiatives in this Section)* 165
Sale of Tobacco in Health Care Facilities/Pharmacies.....................................165
Smokeless Tobacco..166
Government Initiatives: Sale of Tobacco Products, Advertising, Prevention.............166
Government Initiatives: Public Areas..167
Tobacco Industry 167
Tobacco Settlement Funds..167
Violence 167
Hate Crimes 168
Sexual Assault..169
Violence Against Health Care Workers..169
War/Nuclear War...169
Youth Violence 169

ABORTION

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

"That the American Medical Association reaffirm its policy of 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. (P-June 1978, reaffirmed December 1983)"

"Abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the Medical Practice Act of his state. (P-June 1970, reaffirmed June 1973 and December 1986)"

"Neither physician, hospital, nor hospital personnel shall be required to perform an act violative of good medical judgement or personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice. (P-June 1970, reaffirmed December 1970 and June 1973 and December 1986)"

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

ACCIDENT PREVENTION

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

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

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

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

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

The Massachusetts Medical Society shall advocate for functioning seat belts in all passenger seats in taxicabs.

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

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS)

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

1. *HIV/AIDS as a Global Public Health Priority*

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

(f) The MMS supports the efforts of federal and state agencies to increase access to quality care for women and children who are HIV-positive.

2. *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.

3. *Discrimination Based on HIV Seropositivity*

(a) The MMS recognizes the continued discrimination against HIV-infected individuals and condemns any act and opposes any legislation of categorical discrimination based on an individual's actual or presumed disease, including HIV infection. There should be vigorous enforcement of existing anti-discrimination statutes; incorporation of HIV health status in future federal legislation that addresses discrimination; and enactment and enforcement of state and local laws, ordinances, and regulations to penalize those who illegally discriminate based on disease.

(b) The MMS opposes discrimination with regard to access to health care for persons who are seropositive or at risk of HIV infection. Physicians who are unable to provide the services required by HIV-infected patients should make referrals to those physicians or facilities equipped to provide such services.

(c) The MMS supports a federal policy change to ensure blood donation bans or deferrals are applied to donors according to their individual level of risk and are not based on sexual orientation alone.

4. *Reporting of HIV-, HBV-, and HCV-Infected Physicians*

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

5. *Medical Care of HIV-Infected Patients*

(a) The MMS encourages patients who are HIV seropositive or at risk of HIV infection to make their condition known to their physicians and other appropriate health care providers in order to promote access to appropriate medical care and treatment.

(b) Physicians are encouraged to routinely educate all patients about the necessity of the physician obtaining a sexual and substance abuse history.

(c) MMS endorses the incorporation of HIV prevention into the medical care of persons living with HIV. The MMS joins medical and public health organizations in encouraging effective prevention strategies including the use of condoms, pre-exposure prophylaxis of high-risk populations, limitations on breast feeding, abstinence, limiting number of partners, human sexuality education programs, etc., for reducing the risk of HIV/AIDS and other sexually transmitted diseases among the population.

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

6. *Health and Disability Coverage for Health Care Workers at Risk for HIV and Other Serious Infectious Diseases*

Health insurance and/or disability policies of a health care worker should not be terminated, coverage reduced or restricted, or premiums increased solely because of HIV infection.

7. *HIV/AIDS Education*

(a) The MMS endorses the age-appropriate education of students regarding basic knowledge of HIV infection and recommended risk-reduction and anti-discrimination strategies.

(b) The MMS also supports the development of a federal and/or state HIV/AIDS health education program targeted to informing minorities of risk behaviors in a linguistically and culturally-appropriate manner.

(c) The MMS supports continuing medical education instruction for practicing physicians in advances in AIDS care and HIV prevention strategies. Medical institutions should also ensure that medical students and residents are provided the basic clinical science and social issues associated with HIV infection.

8. *HIV/AIDS and Substance Abuse*

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

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

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

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

12. *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.

13. *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.

14. *HIV-Related Health Disparities*
Recognizing the existence of gender, race, and ethnicity disparities in new HIV infections and access to health care for these HIV/AIDS patients, the MMS supports research and policy initiatives aimed at reducing healthcare disparities among HIV/AIDS patients. The MMS encourages improving access to health care for populations disproportionately affected by HIV. The MMS supports continued efforts by the Centers for Disease Control and Prevention in its efforts to evaluate the effectiveness of HIV prevention programs in minority populations. Physicians providing HIV care should make a strong effort to provide linguistically and culturally appropriate care.

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

The MMS reaffirm the AIDS policy (2c) adopted on 2/12/92, and reaffirmed at A-99 and A06, which reads as follows:

That the Massachusetts Medical Society develop programs or mechanisms for referral to existing programs that provide HIV-positive physicians and medical students with financial support, legal advice, disability insurance, emotional support, career counseling and job training.

MMS Council, 2/12/92
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/17/14

The MMS continues to support education for the diagnosis, prevention, and treatment of HIV infection.

MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 5/14/10
(Items 1 and 2 of Original: Sunset)

Approval that the Massachusetts Medical Society develop programs or mechanisms for referral to existing programs that provide HIV-positive physicians and medical students with financial support, legal advice, disability insurance, emotional support, career counseling and job training.

MMS Council, 2/12/92
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/17/14

ADDICTION

Drug Addiction *(Please See Additional Policies under Reproductive Health)*
The MMS will create a Task Force composed of representatives from primary care and specialties, including addiction medicine, to make recommendations regarding communication between physicians when primary responsibility for prescribing opiates changes from one physician to another or when more than one physician prescribes opiates to the same patient, and report back to the HOD at A-15. *(D)*

MMS House of Delegates, 12/6/14

The MMS will work with other appropriate public and private entities to increase access to services for opiate treatment.

The MMS will work with physicians, including those specializing in addictions, to develop ways to increase access to opiate treatment.

The MMS supports efforts to educate physicians about newly available treatment options for addicted patients in primary care and other settings and, in particular, encourage further education around the pharmacologic potential for improved treatment.

MMS House of Delegates, 5/2/03
Reaffirmed and Item 3 Amended and Reaffirmed MMS House of Delegates 5/14/10

Gambling
The Massachusetts Medical Society will advocate and educate regarding the adverse public health effects of gambling as a service to our legislators and other parties interested in objective and factual data. *(D)*

That if casino gambling were to move forward, then the MMS shall advocate for dedicated revenues, at adequate funding levels, for the treatment of public health problems (e.g., alcohol, substance abuse and gambling addictions) which may be aggravated by the presence of casino gambling. *(D)*

MMS House of Delegates, 12/4/10

That in considering the impact of casino gambling, the Legislature should acknowledge the downside of gambling, particularly the negative public health consequences, and should dedicate funding and other appropriate initiatives to mitigate those consequences. *(HP)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14

The Massachusetts Medical Society (MMS) encourages physicians to advise their patients of the addictive potential of gambling. The MMS encourages Massachusetts Government, which operates gambling programs in the Commonwealth of Massachusetts, to provide a fixed percentage of the revenue from gambling for education, prevention, and treatment of gambling addiction. The MMS encourages the Massachusetts Government and any private enterprise, which operates gambling programs in the Commonwealth of Massachusetts, to affix to all lottery tickets, displays at all lottery ticket counters, and at all gambling establishments, a warning sign that states, "You may become addicted to gambling! Gambling a problem? For help call the gambling hotline: 1-800-426-1234."

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

AGING

Long Term Care
The Massachusetts Medical Society will investigate and take appropriate action through educational and legislative means to facilitate appropriate state and federal funding to improve the status of patient care in nursing homes. *(HP)*

MMS House of Delegates, 11/6/00
Amended and Reaffirmed MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14

ALCOHOL

The Massachusetts Medical Society (MMS) shall work with the Department of Public Health to develop a state-funded educational campaign to counteract pressures on young people to drink alcohol.

The MMS will initiate a campaign within the framework of the Society's existing publications and communications, highlighting to the public the dangers of underage drinking and driving. *(D)*

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

ALLIED HEALTH PROFESSIONS AND SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Scope of Practice
The MMS only supports an entity's attempt to increase its scope of practice if: (1) the entity has proven a clear and distinctly identifiable public purpose and benefit, and; (2) has proposed legislation that addresses appropriate supervision, meaningful educational requirements, public protections, and practice standards. *(HP)*
MMS House of Delegates, 5/14/10

AMERICAN MEDICAL ASSOCIATION

Partnership for Growth Agreement
The Massachusetts Medical Society (MMS) will continue its participation in the American Medical Association's (AMA) Partnership for Growth Agreement.

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

AWARDS

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

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

b) Awards need not be presented each year.
(HP)

MMS House of Delegates, 5/2/15
(Item 2 of Original: Auto-sunset)

BLOOD DONATION

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

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

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

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

CHILDREN AND YOUTH

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.

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

Breastfeeding

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

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

The MMS will call upon hospitals to adopt evidence-based policies that have been shown to improve breastfeeding initiation and duration. *(D)*

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

The MMS supports the right of a mother to nurse in public without harassment and encourages breastfeeding-friendly workplaces. *(HP)*

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

Bullying

The MMS will develop and offer cultural competency training for health care providers particularly directed toward those caring for adolescents and young adults in pediatric and family practices and university health care settings. Such training should provide tools to identify and assist at-risk adolescents and young adults with the aim of preventing self harm, suicide, and disability resulting from bullying. *(D)*

The MMS will work to foster more collaboration between health care providers and their local schools to assist educators in protecting their students from bullying by improving their physical and psychological wellness, self esteem, and respect for others. *(D)*

The MMS recognizes that bullying is a particular concern for lesbian, gay, bisexual, transgender youth, and those who are questioning their sexual orientation, and develop education and training for physicians and patients that particularly address the special health care needs of these patients. *(D)*

MMS House of Delegates, 12/4/10

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

MMS House of Delegates, 12/5/15
(Advocacy to AMA Completed, Reported 12/3/16)

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

The MMS will encourage school districts to adopt as policy use of their own emergency supply of epinephrine auto-injectors instead of requiring parents to purchase individually labeled epinephrine auto-injectors for each child and that each student and employee who has life-threatening allergies continue to be required to provide their designated school with an individualized health care plan. *(D)*

The MMS will communicate its policy regarding support for school-supplied epinephrine auto-injectors and the requirement for individualized health care plans for both students and employees to appropriate Massachusetts organizations, including the Massachusetts Association of School Committees, the Massachusetts Association of School Superintendents, and the Massachusetts School Nurse Association. *(D)*

MMS House of Delegates, 12/3/16

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

- Avoid commercial devices marketed to reduce the risk of SIDS. These devices include wedges, positioners, special mattresses, and special sleep surfaces. There is no evidence that these devices reduce the risk of SIDS or suffocation or that they are safe.

- Media and manufacturers should follow safe-sleep guidelines in their messaging and advertising.

(HP)

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

MMS House of Delegates, 12/3/16

Mental Health/Substance Abuse
The Massachusetts Medical Society encourages all primary care practitioners to perform in office physical examinations annually on all adolescents and young adults emphasizing an accurate history regarding the use of illicit drugs, including prescription and non-prescription. *(D)*

The Massachusetts Medical Society supports greater inclusion of behavioral health, including wrap around services, within primary care settings. The MMS supports the elimination of obstacles for payment of these services.*(D)*

The Massachusetts Medical Society will advocate for in-school coordinators to assist students and students’ families with access to mental health counseling as needed. *(D)*

The Massachusetts Medical Society will provide information on mental health, addiction medicine and substance use to physicians, nurse practitioners, physician’s assistants, and physicians-in-training. *(D)*

MMS House of Delegates, 5/17/14

Mindfulness Training
The Massachusetts Medical Society will support its members and other health care providers in educating parents, grandparents, and legal guardians of minors in mindfulness-based stress reduction. *(D)*

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

MMS House of Delegates, 5/7/16

Pediatric Screening Tests
The Massachusetts Medical Society recommends that third party payors henceforth provide payment for reasonable periodic check-ups and screening tests in the pediatric age group up to age 12.

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

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

MMS House of Delegates, 12/7/13

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

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

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

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

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

The MMS will advocate to the Massachusetts Association of School Committees in support of a later start time to the school day (no earlier than 8:30 a.m.) for middle school and high school adolescents. *(D)*

The MMS will advocate for state legislative efforts for later start times for middle school and high school adolescents. *(D)*

MMS House of Delegates, 12/5/15

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

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

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

MMS House of Delegates, 11/8/03
Reaffirmed and Items 1 and 2 Amended and Reaffirmed MMS House of Delegates, 5/14/10

CIVIL AND HUMAN RIGHTS

Military/Medical Policies Affecting Transgender Individuals (Please also see policy under Public Health/
The Massachusetts Medical Society affirms that there is no medically valid reason for the U.S. military to exclude transgender individuals from service or to treat them according to medical standards that differ from those that apply to non-transgender personnel. *(HP)*

The Massachusetts Medical Society requests that its AMA delegation advocate for policy opposing exclusion of transgender individuals from service or that treats them according to medical standards that differ from those that apply to non-transgender personnel. *(D)*

MMS House of Delegates, 5/2/15

Nondiscrimination *(Please Also See Policies under "Public Health, LGBT Patients/Matters")*
The MMS reaffirms its commitment to working for the best possible health care for every patient in the Commonwealth regardless of racial identification, national or ethnic origin, sexual orientation, gender identity, religious affiliation, disability, immigration status, or economic status. *(HP)*

MMS House of Delegates, 12/3/16

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

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

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

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

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

MMS House of Delegates, 12/3/16

The Massachusetts Medical Society will issue a statement in support of medical students, residents, and fellows training in health care, who are Deferred Action for Childhood Arrivals recipients. *(D)*

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

MMS House of Delegates, 12/3/16

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

MMS House of Delegates, 5/2/15

Prompted by recent events in Uganda, the Massachusetts Medical Society strongly condemns all governments that enact laws criminalizing homosexuality or homosexual behavior. *(HP)*

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

MMS House of Delegates, 5/17/14

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

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

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

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

Non-Discrimination Statement

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

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

Torture

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

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

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

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

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

COMMUNICATION

Health Insurance Companies

That the Massachusetts Medical Society file legislation prohibiting representatives of health insurance companies from initiating communications with patients and their families regarding treatment options and code status. *(D)*

MMS House of Delegates, 5/14/10

DRUGS AND PRESCRIPTIONS

Biosimilar Medications

The MMS will advocate via regulatory or legislative avenues that so-called bioequivalent (i.e., generic) substitutions for narrow therapeutic index agents (or those prescribed for treatment of conditions where potential harm of variable bioavailability, prescription to prescription, of said substitution is substantial) not be mandated and/or be limited to no more frequently than once a year, especially for economic reasons alone. This should apply not only to substitutions for branded agents, but also to other generic so-called bioequivalent agents of the same molecular structure. *(D)*

The MMS will advocate via regulatory or legislative avenues that biosimilar medications not be substituted without the express endorsement of the prescribing physician. *(D)*

MMS House of Delegates, 5/21/11

The MMS endorses the following AMA policies:

D-125.989 Substitution of Biosimilar Medicines and Related Medical Products.

Our AMA will: (1) monitor legislative and regulatory proposals to establish a pathway to approve follow-on biological products and analyze these proposals to ensure that physicians retain the authority to select the specific products their patients will receive; and (2) work with the U.S. Food and Drug Administration and other scientific and clinical organizations to ensure that any legislation that establishes an approval pathway for follow-on biological products prohibits the automatic substitution of biosimilar medicines without the consent of the patient's treating physician. (Res. 918, I-08)
(HP)

H-125.980 Follow-on Biologic Medications.

AMA policy is that pharmaceutical companies should be allowed to make follow-on biologic medications available to physicians and their patients in a reasonable period of time with a reasonably predictable pathway to bring them to market, and our AMA will advocate for enactment of federal law that would establish a pathway for follow-on biologic medications to be allowed on the market, with two guiding principles: 1) a reasonable time frame for US Food and Drug Administration exclusivity and patent expiration with a straightforward regulatory process for follow-on biologic competitors to be brought to market, and 2) the protection of patient safety in both the original branded products and all follow-on products that are brought to market. (Res. 220, A-09)
(HP)

The MMS and AMA will work with the FDA and any other relevant regulatory bodies that are responsible for assessing variance in bioequivalency and bioavailability of generic products and branded products so that the MMS and AMA are able to provide policy recommendations. *(D)*

MMS House of Delegates, 12/5/10

Child-Proof/Tamper-Proof Versions

The Massachusetts Medical Society will advocate to health insurers that the presence of a child in the household be cause to cover a child-proof or tamper-proof version of a prescribed drug where available. (*D)*

MMS House of Delegates, 5/19/12

Compounding Pharmacies

That the MMS must act with regards to legislative and regulatory oversight of compounding pharmacies, and in doing so will:

1. Support that traditional compounding pharmacies must be subject to the Massachusetts Board of Registration in Pharmacy oversight and comply with current United States Pharmacopeia and National Formulary (USP-NF) compounding monographs, when available, and recommends that they be required to conform with USP-NF General Chapters on pharmaceutical compounding to ensure the uniformity, quality, and safety of compounded medications.

2. Recognize the accreditation program of the Pharmacy Compounding Accreditation Board (PCAB™) and the PCAB™ Seal of Accreditation as a means to identify compounding pharmacies that adhere to quality and practice standards, including those set forth in the USP-NF, for the preparation of individualized medications for specific patients.

3. Encourage the MA State Board of Pharmacy to require compounding pharmacies to obtain the PCAB™ Seal of Accreditation or, alternatively, to satisfy comparable standards that have been promulgated by the state in its laws

and regulations governing pharmacy practice.

4. Support the view that facilities (other than pharmacies within a health system that serve only other entities within that health system) that compound sterile drug products without receiving a prescription order prior to beginning compounding and introduce such compounded drugs into interstate commerce, be recognized as compounding manufacturers subject to appropriate state and federal oversight and regulation.

5. Support the view that allowances should be made for the conduct of compounding practices that can realistically supply compounded products needed to manage urgent and emergency care scenarios in a safe manner.

In the absence of new federal legislation affecting the oversight of compounding pharmacies, continue to encourage the MA Board of Registration in Pharmacy to work with the appropriate national governmental agencies to identify and take appropriate enforcement action against any entities that are illegally manufacturing medications under the guise of pharmacy compounding.
(D)

MMS House of Delegates, 12/7/13

Copayments/Medications for Chronic Diseases
That key stakeholders work collaboratively and share the results of pilot programs regarding eliminating copayments for generic and essential non-generic medications used to treat chronic diseases, with specific attention to patient compliance and cost-effectiveness. This information should be used as a foundation for further action, as appropriate.
(D)

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

Direct-to-Consumer Advertising
The MMS will advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs. *(D)*

The MMS will request that the AMA advocate to the applicable Federal agencies (including the Food and Drug Administration, the Federal Trade Commission, and the Federal Communications Commission) which regulate or influence direct-to-consumer advertising of prescription drugs that such advertising should be required to state the manufacturer's suggested retail price of those drugs. *(D)*

MMS House of Delegates, 12/3/16

The MMS in its effort to reduce unnecessary medication costs for patients will advocate that all direct-to-consumer advertising expenses by pharmaceutical companies be reported publicly based on uniform accounting procedures, and advocate that such costs shall not be passed on to the public, thereby eliminating increased pricing to the consumer.
(D)

The MMS will collaborate with other state and national medical societies to request that all relevant government agencies require reporting for all direct-to-consumer advertising expenses, and review the pharmaceutical companies' drug development costs and advocate that the direct-to-consumer advertising expenditures are not included in the pricing structure of any pharmaceuticals. *(D)*

MMS House of Delegates, 5/7/16

The MMS will advocate for Massachusetts and federal legislation to ban direct-to-consumer drug ads in Massachusetts and in the United States. *(D)*

MMS House of Delegates, 5/2/15

Drug Formularies
Principles on Prescription Coverage
A. Fundamental Principle
1. <u>Fundamental Principle</u>
The Massachusetts Medical Society (MMS) affirms its commitment to support the access of all patients to medically necessary and appropriate prescription medications.

B. Prescribing

1. Formularies

The MMS supports the continuous development of simplified rational formularies of preferred drugs, and should work with providers and insurers, including Medicare and Medicaid, to achieve this goal. Such formularies should be readily available in print and through electronic media. Physicians should have significant input into all formulary development.

2. Legislative/Regulatory

The MMS shall support legislative and regulatory positions, which support the rights of patients and physicians to choose the appropriate medication for the patient on a clinical basis.

3. Safe and Efficacious Drug Therapies

The MMS believes that the most safe and efficacious drug therapies should be identified by the application of evidence-based medicine.

C. Education

1. Physician Education

Physicians should be continually educated in clinically appropriate, cost-effective prescribing, and should be encouraged to incorporate the information into their prescribing practices.

2. Patient Responsibility

The MMS supports ongoing efforts to provide patients with objective information on medications, their appropriate use, and their cost.

3. Pharmaceutical Industry Input/Insurance Industry Input

Physicians should avoid undue influence from pharmaceutical companies, insurance companies, and health plans that could influence prescription writing. The MMS supports objective education of physicians by independent authorities about prescription and non-prescription drugs.

D. Coverage/Benefits

1. Basic Pharmacy Benefit Coverage

The MMS supports additional allocation of resources for the provision of pharmacy coverage as a basic Medicare benefit.

2. Affordability

The MMS supports efforts to decrease the costs of medications for our patients.

3. Patient Contribution

Cost contributions from patients may be appropriate as long as they do not deter patients' access to prescription medications.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Physicians should be encouraged to use resources appropriately and practice efficiently, including bioequivalent substitution of medications when there is no apparent risk to the patient. *

The Committee on Legislation shall support legislative and regulatory positions which support the rights of patients and physicians to choose the appropriate medication for the patient on a clinical basis.

The Massachusetts Medical Society urges physicians to learn more about the practices of PBMs and become alert to industry-based initiatives in disease management.

The MMS shall continue its work to increase the ready availability to practicing physicians of information about the content of specific formularies.

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Items 2 and 3 of Original: Sunset)

Education Regarding Industry Marketing and Advertising
The MMS will encourage all Massachusetts medical schools and residency programs to educate their students and resident physicians on the possible effects of pharmaceutical, device, and equipment marketing and advertising on care of patients, on various ethical policies on gifts to physicians from industry, and on alternative unbiased sources of information about pharmaceutical products, device, and equipment.

MMS House of Delegates, 5/31/02
Amended and Reaffirmed MMS House of Delegates, 5/8/09
(Items 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16

The MMS supports the concepts that (a) physicians maintain a heightened awareness at all times of the implied and perceived obligations regarding all interactions with the pharmaceutical and medical device industry, and that (b) perception of physicians' behavior should be considered with each contact with industry representatives. *(HP)*

MMS House of Delegates, 11/8/03
Reaffirmed MMS House of Delegates, 5/14/04
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/21/11
(Item 1 of Original: Sunset)

Generic Drugs
Our MMS will advocate for the FDA to waive or reduce entry fees and expedite approval processes for new manufacturers to enter the market for a critical generic medication when the FDA determines that there have been inappropriate significant price increases for that medication. *(D)*

The MMS will advocate for the FDA to allow the importation of a generic medication from selected manufacturers if production of that medication is a monopoly here in the United States. *(D)*

MMS House of Delegates, 5/2/15

The Massachusetts Medical Society will work with the AMA, FDA and any other relevant regulatory bodies to investigate the allowable variance in bioequivalency and bioavailability of generic products and branded products. *(D)*

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

Limits on Medications and Testing or Treatment Supplies
The MMS supports the protection of the patient-physician relationship from interference by insurers' various utilization control mechanisms, including medication limits and testing or treatment supply quantity limits. *(HP)*

The MMS will advocate with third-party payers and federal and state entities to ensure that, if a payer uses quantity limits for prescription drugs or testing and treatment supplies, an exceptions process is in place to make certain that patients can access higher or lower quantities of prescription drugs, testing, or treatment supplies based on medical necessity, and that any such process should minimize the burden upon patients, physicians and their staff. *(D)*

MMS House of Delegates, 12/1/12

Marijuana: Legalization
The MMS will actively engage with state policymakers and other interested parties to advocate for legislative and regulatory policies on legal marijuana in a timely manner that will protect the health of the public, including policies that would:

- Prevent youth access to marijuana including restrictions on marketing and advertising to persons under 21 years of age
- Direct the state to conduct and publish research on the clinical and public health effects of recreational marijuana
- Prevent impaired driving due to marijuana
- Promote education about the health effects of recreational marijuana
- Set safety and quality standards for recreational and medical marijuana
- Direct adequate funding for health and public health interventions related to marijuana, including research, abuse prevention education and treatment, and keep the HOD apprised through report back to the HOD at A-17 and I-17

(D)

That the MMS create an evidence-based resource tool to help physicians respond to the needs of their patients who may be using, or asking about, recreational or medical marijuana. *(D)*

That the MMS work with the Massachusetts Association of Health Boards and other interested parties to develop model regulations for commercial and recreational marijuana for cities and towns. *(D)*

MMS House of Delegates, 12/3/16

Marijuana: Medical Use of *(Please See Additional Policy under Reproductive Health)*
The MMS will work with the MA Board of Registration in Medicine (BORIM) to define the nature of the relevant physician-patient relationship required under "An Act for the Humanitarian Medical Use of Marijuana" including an appropriate reassessment interval and required parent or guardian permission for individuals less than 18 years old. *(D)*

The MMS will advocate for the development of appropriate standards for marijuana certifications by physicians, including that physicians must have an active license from the Massachusetts Board of Registration in Medicine, a Massachusetts Department of Public Health Controlled Substances registration, and a federal Drug Enforcement Agency registration. *(D)*

The MMS will advocate that written certifications for marijuana registration cards are based on:

a) The patient's diagnosis; and

b) The physician's assessment that the patient's symptoms of spasticity, neuropathic pain or other symptoms determined by the Department of Public Health are not optimally controlled with conventional medical therapy; and, be it further *(D)*

The MMS will advocate that the regulations take into consideration the implications of medical use of marijuana on occupational health and safety. *(D)*

The MMS will advocate to the BORIM and the Department of Public Health that relevant regulations include the following recommendations of the American Society on Addiction Medicine adopted April 12, 2010, that physicians who choose to provide certifications:

- …Adhere to the established professional tenets of proper patient care, including
  - o Development of a treatment plan with objectives;
  - o Provision of informed consent, including discussion of side effects;
  - o Periodic review of the treatment's efficacy;
  - o Consultation, as necessary; and
  - o Proper record keeping that supports the decision to recommend the use of cannabis
- …should have a pre-existing and ongoing relationship with the patient as a treating physician
- Ensure that the issuance of "recommendations" is not a disproportionately large (or even exclusive) aspect of their practice
- Have adequate training in identifying substance abuse and addiction. *(D)*

The MMS will advocate with the MA Department of Public Health and the MA Legislature that marijuana dispensing be integrated with, and therefore be part of, the existing DPH Prescription Monitoring Program. *(D)*

The MMS will work with the BORIM to clarify that the mandated peer reporting requirements do not apply to physicians who choose to provide certifications under the Medical Use of Marijuana law. *(D)*

MMS House of Delegates 12/2/12

The Massachusetts Medical Society will advocate that marijuana be reclassified by the U.S. Drug Enforcement Administration so that its potential medicinal use by humans may be further studied and potentially regulated by the U.S. Food and Drug Administration. *(D)*

The Massachusetts Medical Society supports the development of non-smoked, reliable delivery systems for cannabis-derived and cannabinoid medications for research purposes. *(HP)*

The MMS will educate the residents of the Commonwealth that there is insufficient scientific information about the safety of marijuana, when used for "medicinal" purposes. *(D)*

Until such time that scientific studies demonstrate its safety and efficacy, the Massachusetts Medical Society opposes the legalization of medicinal marijuana. *(HP)*

MMS House of Delegates, 5/19/12

Marijuana: Recreational Use of *(Please See Additional Policy under Reproductive Health)*
The Massachusetts Medical Society continues to oppose the legalization of recreational marijuana, as being detrimental to public health. *(HP)*

The Massachusetts Society will advocate and educate regarding the adverse public health effects of recreational marijuana use. *(D)*

The Massachusetts Medical Society will advocate that proposed legislation supporting the legalization of recreational marijuana specifically prohibits individuals under the age of 21 from possessing or using marijuana or marijuana-infused products. *(D)*

The Massachusetts Medical Society will encourage the legislature, in considering the impact of the legalization of recreational marijuana, to acknowledge the potential negative public health consequences. *(D)*

The Massachusetts Medical Society will advocate that proposed legislation supporting recreational marijuana specifically include dedicated revenues, at adequate funding levels, for public education and for the prevention and treatment of health consequences to the public (for example, substance abuse and addiction), which may be aggravated by the use of recreational marijuana. *(D)*

MMS House of Delegates, 12/5/15

The Massachusetts Medical Society affirms its opposition to smoking marijuana for recreational purposes.

The Massachusetts Medical Society recognizes the importance of clinical trials on the medical use of marijuana and its derivatives. All such trials should be approved by an Institutional Review Board process.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Medically-Supervised Injection Facilities
The MMS will perform an internal evidence-based study of the ethical, legal, and liability considerations and feasibility of a medically-supervised injection facility (MSIF) in Massachusetts. *(D)*

That at the conclusion of an internal study of medically-supervised injection facilities (MSIF), the Board of Trustees will report back to the House of Delegates, no later than A-17, with recommendations for an MMS advocacy position on MSIF. *(D)*

MMS House of Delegates, 5/7/16

Medication Withhold/Delays
The Massachusetts Medical Society (MMS) opposes third-party policies that interrupt patients' treatment regimens based on cost savings. *(HP)*

The MMS will work with appropriate regulatory bodies to ensure that neither pharmacies nor other insurer-pharmacy arrangements withhold or delay the filling and mailing of legitimate prescriptions to patients, while they attempt to obtain generic- or alternative-medication prescription changes. *(D)*

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

MMS House of Delegates, 5/19/12

Off-Label Uses
The MMS strongly supports adding to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. *(HP)*

MMS House of Delegates, 5/7/16

The MMS confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA-approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound expert medical opinion. When the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should be required to cover appropriate "off-label" uses of drugs on their formulary. *(HP)*

The MMS strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. *(HP)*

MMS House of Delegates, 5/2/15

The MMS strongly supports the dissemination of generally available information from manufacturers about off-label uses by physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. *(HP)*

The MMS strongly supports the continued authorization, implementation, and coordination of biological license applications and new drug applications to include pediatric safety and effectiveness data. *(HP)*

MMS House of Delegates, 12/5/1

Opioids/Nasal Naloxone
The MMS will oppose legislation that would require prescribers of opioids to provide their patients with less than one week of medication. *(D)*

(Approved MMS Board of Trustees, 3/11/15)
Accepted MMS House of Delegates, 5/7/16

That while MMS strongly supports a fully functionalized and facile PMP, the MMS will oppose the requirement that physicians check the Prescription Monitoring Program (PMP) website prior to issuing all prescriptions for opioids until the Commonwealth substantially improves usability and reduces the time required to use the PMP website. *(D)*

Approved MMS Board of Trustees, 3/11/15)
Accepted MMS House of Delegates, 5/7/16

That the MMS will educate physicians about current law allowing for the prescription and dispensing of nasal naloxone and encourage appropriate prescription for patients at risk for opioid overdose. *(D)*

MMS House of Delegates, 12/1/12

The MMS supports the use of nasal naloxone by medical first responders and trained non-medical personnel for the life-saving reversal of opioid overdose. *(HP)*

The MMS will advocate for the appropriate education of at-risk patients and their caregivers in the signs and symptoms of opioid overdose, and the use of nasal naloxone. *(D)*

Over-the-Counter Medications/Brand-Name Vs. Generic
The MMS will encourage physicians, physician groups, practices, hospitals, and accountable care organizations to re-evaluate the use of brand names when recommending over-the-counter medications in standardized forms such as discharge and post-procedure instructions. *(D)*

The MMS will encourage health care entities to provide both the generic and brand names for over-the-counter medications when making recommendations in discharge, post-procedural care, or verbal instructions. *(D)*

MMS House of Delegates, 5/7/16

Performance Enhancing Drugs
The Massachusetts Medical Society calls upon its members and all physicians to oppose the use of performance enhancing drugs for the purpose of trying to improve athletic performance or for any purpose other than that which is medically indicated.

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

Personal Medication Lists
The MMS will work with the appropriate entities to track developments regarding accessing patients' personal medication lists by providers and patients. *(D)*

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

Prescription Marketing

The Massachusetts Medical Society will work with the American Medical Association and appropriate agencies, including the Food and Drug Administration (FDA), to require that any advertising of prescription medications to the public describe at least one FDA-approved indication for the prescribed medication. *(D)*

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

The Massachusetts Medical Society (MMS) supports the Board of Registration in Pharmacy's review of the practice of pharmacies sending confidential patient information to a computer data-base marketing specialist as a violation of patient confidentiality.

The MMS strongly supports legislation to curtail pharmacy disclosures of confidential patient information.

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

The Massachusetts Medical Society disapproves of the direct product specific advertising of prescription drugs to the public.

MMS House of Delegates, 11/8/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10

Prescription Prices
The MMS will advocate for the Federal Trade Commission to limit anti-competitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through the manipulation of patent protections and abuse of regulatory exclusivity incentives. *(D)*

The MMS will advocate for prescription drug price transparency from pharmaceutical companies, pharmacy benefit managers, and health insurance companies. *(D)*

The MMS will advocate for monitoring of relationships between pharmacy benefits managers and the pharmaceutical industry, and discourage arrangements that cause an increased cost, or decreased availability, of prescription drugs. *(D)*

The MMS will advocate at the Massachusetts State House and Office of the Attorney General to bring attention to rises in drug prices and initiate patient protection actions regarding excessive drug pricing. *(D)*

MMS House of Delegates, 12/5/15

*The MMS will work toward eliminating Medicare prohibition on drug price negotiation. *(D)*

MMS House of Delegates, 12/6/14
Reaffirmed MMS House of Delegates, 12/5/15
*(*Reaffirmation was part of 12/15 item above)*
(Item 1 of Original: Auto-Sunset 12/16)

The Massachusetts Medical Society supports legislation to create a voluntary negotiated price reduction program with pharmaceutical companies that lowers prescription drug prices in order to make them affordable for the citizens of the Commonwealth of Massachusetts.

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

The Massachusetts Medical Society supports federal legislation to authorize waivers for state demonstration projects to allow states to negotiate and purchase drugs on behalf of Medicare Part D beneficiaries utilizing existing revenues, and to create and implement alternative prescription drug programs for beneficiaries. *(D)*

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

Prescription Writing/E-Prescribing

The MMS will continue to work to remove all barriers to complete prescribing by electronic means, including allowing for the use of scheduled medications. *(D)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15
Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society opposes psychologists obtaining prescription privileges in Massachusetts. *(HP)*

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

The MMS will work with appropriate partners to develop legislation promoting patient safety, efficiency and security for the electronic submission of prescriptions in Massachusetts. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Item 2 of Original: Reaffirmed MMS House of Delegates, 5/7/16 (Items 1 and 3 Sunset)
Reaffirmed MMS House of Delegates, 5/7/16

Reduction of Illegal Drug Use

The Massachusetts Medical Society supports enhanced medical and public health approaches as effective methods of reducing the illegal use of illegal drugs.

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

Return of Unused and/or Expired Medications

The Massachusetts Medical Society supports the policy that all unused nursing home drugs, which are sealed and dated, be returned for credit.

The Massachusetts Medical Society, in collaboration with the Massachusetts chapter of the American Medical Directors Association and the Massachusetts chapter of the American Geriatric Society, urges the Massachusetts Department of Public Health to expand its current medication return list. *(D)*

The Massachusetts Medical Society urges Massachusetts Congressional members to draft legislation supporting the recycling of unused nursing home drugs, which are sealed and dated. *(D)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Item 1: Reaffirmed MMS House of Delegates, 5/14/10
Items 2 and 3: Amended and Reaffirmed MMS House of Delegates, 5/21/11

The MMS will request that the AMA advocate to the FDA and Congress to require that all pharmacies have a “take back and disposal” policy for unused and expired medications and that disposal of the collected unused and expired medication is handled in an environmentally safe manner, such as incineration or other suitable method. *(D)*

MMS House of Delegates, 5/21/11

Sharing of Prescribing Data
The Massachusetts Medical Society will investigate legal, regulatory, legislative, or other approaches and take appropriate action to ban the sharing of individual providers' prescribing data by pharmacies, hospitals, insurers, or other entities with companies not involved in legitimate peer-review or utilization-review activities. *(D)*

MMS House of Delegates, 11/4/06
Reaffirmed MMS House of Delegates, 5/11/13

Substance Use and Misuse
The MMS supports the state-wide implementation of accessible jail diversion programs for individuals with substance use disorders. *(HP)*

The MMS will work with the legislature, the Department of Public Health, and other appropriate agencies to advocate for expanded government funding to substance use disorder treatment programs with the intention of expanding capacity. *(D)*

MMS House of Delegates, 5/7/16

The MMS will examine public policy toward drug abuse and addiction with a goal of developing policy based on a medical treatment model of response with a report back to the HOD at the 2017 Annual Meeting. *(D)*

MMS House of Delegates, 5/7/16

EMERGENCY MEDICAL SERVICES

CPR Programs/Public Access Defibrillation

The Massachusetts Medical Society (MMS) will advocates for the availability of accessible automated external defibrillators (AEDs) and severe bleeding kits in schools, colleges, and other public places. *(HP)*

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

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

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

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

The Massachusetts Medical Society (MMS) endorses and recommends Basic CPR, AED, and first aid training and certification of high school students.

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 hereby indicates its support of AMA approved training programs in CPR. The MMS asks the staff presidents of the hospitals of Massachusetts (or their designees) to put into effect by July 1, 1981, programs that will assure training in basic life support.

MMS Council, 10/8/80
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 11/4/06

The Massachusetts Medical Society will advocate for public access defibrillation. *(D)*

MMS House of Delegates, 11/8/03
Amended and Reaffirmed MMS House of Delegates, 5/14/10

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

The MMS formally recognizes that the solution to the boarding of patients in emergency departments must focus on the timely outflow of patients from the emergency department, not on restrictive barriers to access.

The MMS shall use its best efforts to work to eliminate emergency department boarding of patients.

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

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

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

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

ENVIRONMENTAL HEALTH

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

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

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

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

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

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

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

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

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

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

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

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

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

The MMS appeals to the Commonwealth of Massachusetts to so enforce laws related to air quality in the workplace.

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

Biodiversity

The Massachusetts Medical Society (MMS) shall inform physicians and other health care providers utilizing existing mechanisms, about the importance of the protection of biodiversity and its relationship to human health, especially in terms of the development of drugs and biologicals that are derived from plants, animals, and other elements of the natural world and used to treat disease.

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

Biomass Plants

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

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

Chemical/Environmental Exposures

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

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

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

MMS House of Delegates, 5/14/10

The MMS endorses the AMA policy on modern and industrial chemicals adopted by the AMA in June, 2008, which reads as follows:

> Our American Medical Association calls upon the United States government to implement a national modern, comprehensive chemicals policy that is in line with current scientific knowledge on human and environmental health, and that requires a full evaluation of the health impacts of both newly developed and industrial chemicals now in use.
>
> Our American Medical Association support the restructuring of the Toxic Substances Control Act to serve as a vehicle to help federal and state agencies to assess efficiently the human and environmental health hazards of industrial chemicals and reduce the use of those of greatest concern.
>
> Our AMA support the Strategic Approach to International Chemicals (SAICM) process leading to the sound management of chemicals throughout their life-cycle so that, by 2020, chemicals are used and produced in ways that minimize adverse effects on human health and the environment.
>
> Our American Medical Association encourage the training of medical students, physicians, and other health professionals about the human health effects of toxic chemical exposures.

(HP)

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

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

> The MMS concurs with the findings of the Intergovernmental Panel on Climate Change's fifth assessment report that "human influence on the climate system is clear, and recent anthropogenic emissions of greenhouse gases are the highest in history"; that "recent climate changes have had widespread impacts on human and natural systems"; that "climate change will amplify existing risks and create new risks for natural and human systems"; and "that risks are unevenly distributed and are generally greater for disadvantaged people and communities in countries at all levels of development." *(HP)*
>
> The MMS recognizes the importance of physician involvement in policymaking at the state, national, and global levels and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect human health. *(HP)*
>
> The MMS encourages physicians to consider and promote environmentally responsible policies and practices in the health care setting. *(HP)*

The MMS will pursue a suitable way to invest a portion of its Portfolio in an appropriate alternative ("clean") energy fund and report back on progress and status to the HOD at I-17. *(D)*

The MMS will consider and report back on a shift of non-pension investments into socially-responsible investments. *(D)*

MMS House of Delegates, 12/3/16

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

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

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

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

Mercury
The Massachusetts Medical Society (MMS) encourages physicians to inform patients about mercury advisories for fish.

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

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

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

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

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

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

The Massachusetts Medical Society:

strongly urges government authorities to see that scientific knowledge, when available, is applied evenly and firmly not only in respect of nuclear energy, but for other energy sources as well.

MMS Council, 2/11/81
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Item 3: Reaffirmed MMS House of Delegates, 5/11/13
(Items1-2 of Original: Sunset)

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

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

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

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

ETHICS

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

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

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

3. Physician Review of Accounts Designated for Collection. The decision to send a patient account to collection may have ethical ramifications due to the potentially serious consequences for the patient and the physician/patient relationship. Physicians are encouraged to review their accounting/collection policies to ensure that no patient's account is sent to collection without the physician's knowledge. (AMA Council on Ethical and Judicial Affairs Opinion 6.08 "Interest Charges and Finance Charges,"(1998-99 ed.). Employers should accord employed physicians the opportunity to review their patients' accounts prior to such accounts being sent to collection. If physician review of all accounts is impractical, it may be appropriate for physicians to review only those accounts where the patient or patient's representative has communicated with the physician's office about the delinquent bill.
4. Content of Billing and Collection Policies. Billing and collection policies should be reasonable and should not conflict with applicable state and federal law and the physician's ethical duties to his or her patient.

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

6. Professional Courtesy. Professional courtesy refers to the provision of medical care to physician colleagues or their families free of charge or at a reduced rate. While professional courtesy is a long-standing tradition in the medical profession, it is not an ethical requirement. Physicians should use their own judgment in deciding whether to waive or reduce their fees when treating fellow physicians or their families. Physicians should be

aware that accepting insurance payments while waiving patient co-payments may violate CEJA Ethical Opinion 6.12. (AMA CEJA Opinion 6.13, "Professional Courtesy.")

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

   A number of clinics have advertised their willingness to provide detailed medical evaluations and accept the insurer's payment but waive the co-payment for all patients. Cases have been reported in which some of these clinics have conducted excessive and unnecessary medical testing while certifying to insurers that the testing is medically necessary. Such fraudulent activity exacerbates the high cost of health care, violates [CEJA] Opinion 2.19, and is unethical.

   Physicians should be aware that forgiveness or waiver of co-payments may violate the policies of some insurers, both public and private; other insurers may permit forgiveness or waiver if they are aware of the reasons for the forgiveness or waiver. Routine forgiveness or waiver of co-payments may constitute fraud under state and federal law. Physicians should ensure that their policies on co-payments are consistent with applicable law and with the requirements of their agreements with insurers. (AMA CEJA Opinion 6.12, "Forgiveness or Waiver of Insurance Co-payments.")

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

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 re-evaluating 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

Cloning

The Massachusetts Medical Society shall adopt the American Medical Association (AMA) policy regarding the Ethics of Human Cloning, which reads as follows:

1. In order to clarify the many existing misconceptions about human cloning, physicians should help educate the public about the intrinsic limits of human cloning as well as the current ethical and legal protections that would prevent abuses of human cloning. These include the following:
    a) Using human cloning as an approach to terminal illness or mortality is a concept based on the mistaken notion that one's genotype largely determines one's individuality. A clone-child created via human cloning would not be identical to his or her clone-parent.

    b) Current ethical and legal standards hold that under no circumstances should human cloning occur without an individual's permission.

    c) Current ethical and legal standards hold that a human clone would be entitled to the same rights, freedoms, and protections as every other individual in society. The fact that a human clone's nuclear genes would derive from a single individual rather than two parents would not change his or her moral standing.

2. Physicians have an ethical obligation to consider the harms and benefits of new medical procedures and technologies. Physicians should not participate in human cloning at this time because further investigation and discussion regarding the harms and benefits of human cloning is required. Concerns include:
    a) Unknown physical harms introduced by cloning. Somatic cell nuclear transfer has not yet been refined and its long-term safety has not yet been proven. The risk of producing individuals with genetic anomalies gives rise to an obligation to seek better understanding of, and potential medical therapies for, the unforeseen genetic consequences that could stem from human cloning.

    b) Psychosocial harms introduced by cloning, including violations of privacy and autonomy. Human cloning promises to limit, at least psychologically, the seemingly unlimited potential of new human beings and to create enormous pressures on the clone-child to live up to the expectations based on the life of the clone-parent.

    c) The impact of human cloning on familial and societal relations. The family unit would be different with the introduction of cloning, and more thought is required on a societal level regarding how to construct familial relations.

    d) Potential effects on the gene pool. Like other interventions that can change individuals' reproductive patterns and the resulting genetic characteristics of a population, human cloning has the potential to be used in a eugenic or discriminatory fashion, practices that are incompatible with the ethical norms of medical practice. Moreover, human cloning could alter irreversibly the gene pool and exacerbate genetic problems that arise from deleterious genetic mutations, resulting in harm to future generations.

3. Two potentially realistic and possibly appropriate medical uses of human cloning are for assisting individuals or couples to reproduce and for the generation of tissues when the donor is not harmed or sacrificed. Given the unresolved issues regarding cloning identified above, the medical profession should forsake human cloning at this time and pursue alternative approaches that raise fewer ethical concerns.

4. Because cloning technology is not limited to the United States, physicians should help establish international guidelines governing human cloning.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

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

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

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

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

Confidentiality: Statement of Principles

General Principles

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

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

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

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

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

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

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

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

Principles Pertaining to Confidentiality of Medical Information in Health Insurance

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

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

(3) Every insurer should formally disclose in writing to each individual adult covered by the health plan the insurer's specific policies and procedures for accessing confidential patient information, including the

uses for which medical information is sought and the numbers and functions of persons who have access to it. This written information should be supplied at least annually.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Principles Pertaining to Information Technology and Electronic Medical Records

(1) Electronic medical records offer an opportunity for dramatic benefits to patients in clinical care, research and the delivery of health care. However, electronic records will not be capable of providing these benefits unless patient privacy and confidentiality are strengthened, not jeopardized, by new policy governing information technologies.

(2) Regarding the electronic record, as with the paper record, the patient has the right to privacy and confidentiality of his/her personally identified medical information.

(3) For any individual or organizations with authorized access to the electronic medical record, the level of access permitted should be specifically identified in advance. Full disclosure of this information to the patient is necessary.

(4) Patient data should be assigned security protections that should be used to control who has access to the information. In addition, mandatory audit trails to determine who had accessed the electronic record should be maintained and made available to the attending physician, and to the patient upon the patient's request.
(5) Physicians should be educated about technologies of security.
(6) In systems of electronic medical records, patients, in consultation with their physicians, should be able to specify what information should not be disseminated.
(7) While offering potential clinical and research benefits, systems designed to encourage data linkage through the mandatory use of unique health identifiers or standard code sets may jeopardize patient privacy and should require patient consent.
(8) Patient-specific information should not be released to data clearinghouses without meaningful notice to and consent of the patient, and assurance of privacy and confidentiality.
(9) Organizations concerned with the development of electronic medical records should be encouraged to pursue research, development and education in matters related to privacy and confidentiality.
(10) Firm, explicit state and federal statutes should regulate access to identified confidential electronic patient data and define punitive measures for negligence and deliberate violation of security measures. (Amended 5/7/16)

Principles Pertaining to Genetic Information

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

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

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

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

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

Principles Pertaining to Research

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

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

Principles Pertaining to Public Safety

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

Principles Pertaining to Marketing and Commercial Use

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

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

(HP)

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 12/3/11
Amended and Reaffirmed MMS House of Delegates, 5/7/16

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

Ethics and Managed Care
Preamble:

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

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

Changes in the practice environment now require physicians to examine their professional relationships even more closely. The following principles are offered to reaffirm the primacy of the traditional physician-patient relationship and the standards of conduct between and among colleagues. They also seek to clarify appropriate conduct between physicians and health care organizations that challenge traditional models of medical practice.

PHYSICIAN TO PATIENT RELATIONSHIP

(1) Patient Advocacy Is Fundamental
The duty of patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interest of their patients first. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(2) Advocacy for Patient Benefit
Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care).

(3) Primacy of Patient Welfare over Physicians' Financial Interests
While physicians should be conscious of costs and not provide or prescribe unnecessary services, concern for the quality of care the patient receives should be the physician's first concern. Under no circumstances may physicians place their own financial interests above the welfare of their patients. The primary objective of the medical profession is to render service to humanity: Reward or financial gain is a subordinate consideration. For a physician to unnecessarily hospitalize a patient, prescribe a drug, or conduct diagnostic tests for the physician's financial benefit is unethical. Similarly, to limit appropriate diagnostic tests, referrals, hospitalization, or treatment, for the physician's financial benefit is unethical. If a conflict develops between

the physician's financial interest and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit. (Adapted from AMA CEJA Opinion 8.03 Conflicts of Interest: Guidelines, Adapted from AMA CEJA Opinion 2.09 Costs)

(4) Physician Participation in Allocation Process
Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis, be evidence based whenever feasible, and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

(5) Appeals from Denials of Care
Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise when a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician's duty as patient advocate requires not only a challenge to any
denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

A physician should be able to assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Disclosure of Financial Incentives to Patients by Plan and by Physician
Health Plans must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians must clearly and adequately respond to inquiries by patients regarding any financial incentives. The health plans must make adequate disclosure to patients enrolled in the plan at enrollment and annually thereafter. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (Adapted from MA Policy 285.998: Managed Care #4, Financial Incentives)

PHYSICIAN TO PHYSICIAN

(1) Negotiating Contracts between Physicians
Negotiating contracts between physicians in a health plan is ethical and appropriate only if the standard of care is the same for all patients and there is disclosure to the patients of the financial arrangements that may affect their care.

(2) Referrals to Specialists
Patients are entitled to all the benefits outlined in their insurance plan. Therefore, it is unethical for a referring physician to restrict the referral options of patients who have chosen a plan that provides for access to an unlimited or broad selection of specialist physicians. It is also unethical to base the referral of these patients on a discount for the capitated patients in a primary care physician's practice. Physicians should not be restricted from informing their patients of out-of-plan specialists, when their expertise may offer important advantages to the patient. (Adapted from AMA CEJA Opinion 8.052 Negotiating Discounts for Specialty Care; MMS Policy)

(3) Financial Inducements
Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical. (AMA CEJA Opinion 6.02 Fee Splitting)
A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. (AMA CEJA Opinion 6.02 Fee Splitting)

These payments violate the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. (Adapted from AMA CEJA Opinion 6.02 Fee Splitting)

PHYSICIAN TO HEALTH CARE ORGANIZATION

(1) Non-participation in Unprofessional Care

Physicians should not participate in any organization that encourages or requires care at below minimum professional standards, unless actively involved in trying to change and improve the deficient standards. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Physicians who have administrative and/or executive responsibilities in health care organizations should be knowledgeable about medical ethics and should encourage the health care organization to make ethically appropriate medical decisions. (Task Force on Ethical Standards in Managed Care, MMS 1996)

(2) Incentives to Limit Care

Health plans should not establish financial incentives or quotas that interfere with appropriate clinical management such as limiting diagnostic tests, services, referrals, or access to care. (MMS Policy)

When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care. (AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

Physician payments that provide an incentive to limit the utilization of services should not link financial rewards with individual treatment decisions over periods of time insufficient to identify patterns of care or expose the physician to excessive financial risk for services provided by physicians or institutions to whom he or she refers patients for diagnosis or treatment. When risk sharing arrangements are relied upon to deter excess utilization, physician incentive payments should be based on performance of groups of physicians rather than individual physicians, and should not be based on performance over short periods of time. (AMA Policy 285.982: Ethical Issues in Managed Care; Adapted from AMA CEJA Opinion 8.054 Financial Incentives and the Practice of Medicine)

The magnitude of fee withholds, bonuses and other financial incentives should not affect provision of appropriate care. (Adapted from AMA Policy 285.982: Ethical Issues in Managed Care; AMA CEJA Opinion 8.13 Managed Care Guidelines)

(3) Allocation Guidelines and Policy Making

Any broad allocation guidelines that restrict care and choices, which go beyond the cost/benefit judgments made by physicians as part of their normal professional responsibilities, should be established at a policy-making level so that individual physicians are not asked to engage in ad hoc bedside rationing. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for care they believe will materially benefit their patients. (Adapted from AMA CEJA Opinions 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(4) Physician Participation in Allocation Process

Practicing physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create organizational structures that allow practicing physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(5) Appeals from Denials of Care

Adequate and timely appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise in which a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline but also advocacy at the health plan's policy-making level to seek an elimination or modification of the guideline. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

A physician should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(6) Informed Consent and Plan Disclosure
Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan and on annual re-enrollment. (Adapted from AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(7) Full Disclosure to Patients
Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by a limitation in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all of their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate, or whether they wish to seek care outside the plan for treatment alternatives that are not covered. (AMA CEJA Opinion 8.13 Managed Care Guidelines; AMA Policy 285.982: Ethical Issues in Managed Care)

(8) Disclosure of Incentives to Patients, by Plan and by Physician
Health Plans must disclose any financial inducements or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients or restrict referral or treatment options. Physicians must clearly and adequately respond to inquiries by patients regarding any financial incentives. Health plans must make adequate disclosure to patients enrolled in the plan at enrollment and annually thereafter. Physicians must also inform their patients of medically appropriate treatment options regardless of their cost or the extent of their coverage. (Adapted from AMA Policy 285.998: Managed Care)

(9) Medical Judgments and Plan Administration
Physicians may work directly for plans or may be employed by the medical group or the hospital that has contracted with the plan to provide services. In the operation of such plans, physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve. Assuming a title or position that removes the physician from direct patient-physician relationships, such as the title of Medical Director, does not override professional ethical obligations. (AMA CEJA Opinion 8.05 Contractual Relationships, AMA CEJA Opinion 8.021 Ethical Obligations of Medical Directors.)

(10) Physician Contracts and Plan Administration
Physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but should be aware of the potential for some types of systems to create conflicts of interest because of financial incentives to withhold medically indicated services. Physicians must not allow such financial incentives to influence their judgment of appropriate therapeutic alternatives or deny their patient's access to appropriate services based on such inducements. (Adapted from AMA Policy 285.998: Managed Care)

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

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

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

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

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

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

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

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

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

7. Genetic testing results can provide valuable information to be considered by individuals making reproductive choices. MMS opposes, however, the use of genetic testing results by persons or institutions, other than the patient[s] from whom the genetic information was derived, to influence the reproductive choice of the patient[s] from whom the genetic information was derived.

8. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in **insurance coverage** which reads as follows:

The Massachusetts Medical Society adopts the AMA Policy H-185.972 regarding Genetic Information and Insurance Coverage, which reads as follows:

(1) Health insurance providers should be prohibited from using genetic information, or an individual's request for genetic services, to deny or limit any health benefit coverage or establish eligibility, continuation, enrollment or contribution requirements.

(2) Health insurance providers should be prohibited from establishing differential rates or premium payments on genetic information or an individual's request for genetic services.

(3) Health insurance providers should be prohibited from requesting or requiring collection or disclosure of genetic information.

(4) Health insurance providers and other holders of genetic information should be prohibited from releasing genetic information without express prior written authorization of the individual. Written authorization should be required for each disclosure and include to whom the disclosure be made.

(MMS House of Delegates, 11/21/97)
(Reaffirmed MMS House of Delegates, 5/14/04)
Reaffirmed (Entire Policy) MMS House of Delegates, 5/21/11

9. The Massachusetts Medical Society hereby affirms existing policy regarding genetic discrimination in the workplace, which reads as follows:

The Massachusetts Medical Society adopts the AMA policy E-2.132 regarding **Genetic Testing by Employers** which reads:

As a result of the human genome project, physicians will be able to identify a greater number of genetic risks of disease. Among the potential uses of the tests that detect these risks will be screening of potential workers by employers. Employers may want to exclude workers with certain genetic risks from the workplace because these workers may become disabled prematurely, impose higher health care costs, or pose a risk to public safety. In addition, exposure to certain substances in the workplace may increase the likelihood that a disease will develop in the worker with a genetic risk for the disease.

(1) It would generally be inappropriate to exclude workers with genetic risks of disease from the workplace because of their risk. Genetic tests alone do not have sufficient predictive value to be relied upon as a basis for excluding workers. Consequently, use of the tests would result in unfair discrimination against individuals who have positive test results. In addition, there are other ways for employers to serve their legitimate interests. Tests of a worker's actual capacity to meet the demands of the job can be used to ensure future employability and protect the public's safety. Routine monitoring of a worker's exposure can be used to protect workers who have a genetic susceptibility to injury from a substance in the workplace. In addition, employees should be advised of the risks of injury to which they are being exposed.

(2) There may be a role for genetic testing in the exclusion from the workplace of workers who have a genetic susceptibility to injury. At a minimum, several conditions would have to be met:

(a) The disease develops so rapidly that serious and irreversible injury would occur before monitoring of either the worker's exposure to the toxic substance or the worker's health status could be effective in preventing harm.
(b) The genetic testing is highly accurate, with sufficient sensitivity and specificity to minimize the risk of false negative and false positive test results.
(c) Empirical data demonstrate that the genetic abnormality results in an unusually elevated susceptibility to occupational injury.
(d) It would require undue cost to protect susceptible employees by lowering the level of the toxic substance in the workplace. The costs of lowering the level of the substance must be extraordinary relative to the employer's other costs of making the product for which the toxic substance is used. Since genetic testing with exclusion of susceptible employees is the alternative to cleaning up the workplace, the cost of

lowering the level of the substance must also be extraordinary relative to the costs of using genetic testing.

(e) Testing must not be performed without the informed consent of the employee or applicant for employment.

(3) That the Massachusetts Medical Society agrees that employers should be prohibited from requesting, obtaining, or using genetic information to hire or fire an employee, or set terms, conditions, privileges, or benefits of employment, unless the employment organization can prove this information is job related and consistent with CEJA opinion 2.132.

(4) That employers should be prohibited from disclosing genetic information.

(MMS House of Delegates, 11/21/97)
(Reaffirmed, MMS House of Delegates, 5/14/04)
(Reaffirmed MMS House of Delegates, 5/21/11)

10. Appreciating the acceleration of new information in the field of genetics, the Massachusetts Medical Society will develop a plan to educate physicians throughout the state (through venues such as conferences and interactive or on-line learning tools and curricula suitable for Grand Rounds, etc), regarding the basic and current principles of genetic information and testing, and the clinical, social and legal implications of such advancing technologies.

(MMS House of Delegates, 11/6/99)

Reaffirmed (Entire Policy) MMS House of Delegates, 5/21/11

Gifts to Physicians from Industry

In keeping with current ethical standards, the MMS may engage in advocacy to modify the Massachusetts gift ban law if:

1. The advocacy advances patient interest, *and*
2. The modification sought would conform to the guidelines of the American Medical Association and the Accreditation Council on Continuing Medical Education regarding industry gifts to physician, *and*
3. The advocacy effort does not adversely affect public trust, or the benefit to the patient from modification of the law outweighs the ethical impact of any potential adverse effect on public trust.

(HP)

MMS House of Delegates, 5/19/12

That the Massachusetts Medical Society (MMS) endorses as an opinion the American Medical Association Council on Ethical and Judicial Affairs Opinion 8.061 and Clarification, “Gifts to Physicians from Industry,” issued June 1992, which reads:

Many gifts given to physicians by companies in the pharmaceutical, device, and medical equipment industries serve an important and socially beneficial function. For example, companies have long provided funds for educational seminars and conferences. However, there has been growing concern about certain gifts from industry to physicians. Some gifts that reflect customary practices of industry may not be consistent with the Principles of Medical Ethics. To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

(1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members.

(2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician’s work (e.g., pens and notepads).

(3) The Council on Ethical and Judicial Affairs defines a legitimate “conference” or “meeting” as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees

together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.

(4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's representative may create a relationship that could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

(5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.

(6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional or specialty medical associations.

(7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures. (II) Issued June 1992 based on the report "Gifts to Physicians from Industry," adopted December 1990 (JAMA. 1991; 265: 501 and Food and Drug Law Journal. 2001; 56: 27-40); Updated June 1996 and June 1998.

Clarification of Opinion 8.061

Scope

Opinion 8.061, "Gifts to Physicians from Industry" is intended to provide ethical guidance to physicians. Other parties involved in the health care sector, including the pharmaceutical, devices and medical equipment industries and related entities or business partners, should view the guidelines as indicative of standards of conduct for the medical profession. Ultimately, it is the responsibility of individual physicians to minimize conflicts of interest that may be at odds with the best interest of patients and to access the necessary information to inform medical recommendations. The guidelines apply to all forms of gifts, whether they are offered in person, through intermediaries, or through the Internet. Similarly, limitations on subsidies for educational activities should apply regardless of the setting in which, or the medium through which, the educational activity is offered.

General questions:

(a) Do the guidelines apply only to pharmaceutical, device, and equipment manufacturers?

"Industry" includes all "proprietary health-related entities that might create a conflict of interest."

Guideline 1

Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or for use by family members.

(a) May physicians accept gram stain test kits, stethoscopes or other diagnostic equipment?

Diagnostic equipment primarily benefits the patient. Hence, such gifts are permissible as long as they are not of substantial value. In considering the value of the gift, the relevant measure is not the cost to the company of providing the gift. Rather, the relevant measure is the cost to the physician if the physician purchased the gift on the open market.

(b) May companies invite physicians to a dinner with a speaker and donate $100 to a charity or medical school on behalf of the physician?

There are positive aspects to the proposal. The donations would be used for a worthy cause, and the physicians would receive important information about patient care. There is a direct personal benefit to the physician as well, however. An organization that is important to the physician - and one that the physician might have ordinarily felt obligated to make a contribution to - receives financial support as a result of the physician's decision to attend the meeting. On balance, physicians should make their own judgment about these inducements. If the charity is predetermined without the physician's input, there would seem to be little problem with the arrangement.

(c) May contributions to a professional society's general fund be accepted from industry?

The guidelines are designed to deal with gifts from industry which affect, or could appear to affect, the judgment of individual practicing physicians. In general, a professional society should make its own judgment about gifts from industry to the society itself.

(d) When companies invite physicians to a dinner with a speaker, what are the relevant guidelines?

First, the dinner must be a modest meal. Second, the guideline does allow gifts that primarily benefit patients and that are not of substantial value. Accordingly, textbooks and other gifts that primarily benefit patient care and that have a value to the physician in the general range of $100 are permissible. When educational meetings occur in conjunction with a social event such as a meal, the educational component must have independent value, such as a presentation by an authoritative speaker other than a sales representative of the company. Also, the meal should be a modest one similar to what a physician routinely might have when dining at his or her own expense. In an office or hospital encounter with a company representative, it is permissible to accept a meal of nominal value, such as a sandwich or snack.

(e) May physicians accept vouchers that reimburse them for uncompensated care they have provided?

No. Such a voucher would result directly in increased income for the physician.

(f) May physicians accumulate "points" by attending several educational or promotional meetings and then choose a gift from a catalogue of education options?

This guideline permits gifts only if they are not of substantial value. If accumulation of points would result in physicians receiving a substantial gift by combining insubstantial gifts over a relatively short period of time, it would be inappropriate.

(g) May physicians accept gift certificates for educational materials when attending promotional or educational events?

The Council views gift certificates as a grey area which is not per se prohibited by the guidelines. Medical text books are explicitly approved as gifts under the guidelines. A gift certificate for educational materials, i.e., for the selection by the physician from an exclusively medical text book catalogue, would not seem to be materially different. The issue is whether the gift certificate gives the recipient such control as to make the certificate similar to cash. As with charitable donations, pre-selection by the sponsor removes any question. It is up to the individual physician to make the final judgment.

(h) May physicians accept drug samples or other free pharmaceuticals for personal use or use by family members?

The Council's guidelines permit personal or family use of free pharmaceuticals:

(i) in emergencies and other cases where the immediate use of a drug is indicated,
(ii) on a trial basis to assess tolerance and
(iii) for the treatment of acute conditions requiring short courses of inexpensive therapy, as permitted by Opinion E-8.19: Self-Treatment or Treatment of Immediate Family Members.
It would not be acceptable for physicians to accept free pharmaceuticals for the long-term treatment of chronic conditions.

(i) May companies invite physicians to a dinner with a speaker and offer them a large number of gifts from which to choose one?

In general, the greater the freedom of choice given to the physician, the more the offer seems like cash. A large number of gifts presented to physicians who attend a dinner would therefore be inappropriate.

There is no precise way of deciding an appropriate upper limit on the amount of choice that is acceptable. However, it is important that a specific limit be chosen to ensure clarity in the guidelines. A limit of eight has been chosen because it permits flexibility but prevents undue freedom of choice. Each of the choices must have a value to the physicians of no more than $100.

(j) May physicians charge for their time with industry representatives or otherwise receive material compensation for participation in a detail visit?

Guideline 1 states that gifts in the form of cash payments should not be accepted. Also, Guideline 6 makes clear that, in the context of the industry-physician relationship, only physicians who provide genuine services may receive reasonable compensation. When considering the time a physician spends with an industry representative, it is the representative who offers a service, namely the presentation of information. The physician is a beneficiary of the service. Overall, these guidelines do not view that physicians should be compensated for the time spent participating in educational activities, nor for time spent receiving detail information from an industry representative.

Guideline 2

Individual gifts of minimal value are permissible as long as the gifts are related to the physician's work (e.g., pens and notepads).

(a) May physicians, individually or through their practice group, accept electronic equipment, such as hand held devices or computers, intended to facilitate their ability to receive detail information electronically?
Although Guideline 2 recognizes that gifts related to a physician's practice may be appropriate, it also makes clear that these gifts must remain of minimal value. It is not appropriate for physicians to accept expensive hardware or software equipment even though one purpose only may pertain to industry-related activities of a modest value.

Guideline 3

The Council on Ethical and Judicial Affairs defines a legitimate "conference" or "meeting" as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.

Guideline 4

Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company's sales representative may create a relationship which could influence the use of the company's products, any subsidy should be accepted by the conference's sponsor who in turn can use the money to reduce the conference's registration fee. Payments to defray the costs of a conference should not be accepted directly from the company by the physicians attending the conference.

(a) Are conference subsidies from the educational division of a company covered by the guidelines?

Yes. When the Council says "any subsidy," it would not matter whether the subsidy comes from the sales division, the educational division or some other section of the company.

(b) May a company or its intermediary send physicians a check or voucher to offset the registration fee at a specific conference or a conference of the physician's choice?

Physicians should not directly accept checks or certificates which would be used to offset registration fees. The gift of a reduced registration should be made across the board and through the accredited sponsor.

Guideline 5

Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians' time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.

(a) If a company invites physicians to visit its facilities for a tour or to become educated about one of its products, may the company pay travel expenses and honoraria?

This question has come up in the context of a rehabilitation facility that wants physicians to know of its existence so that they may refer their patients to the facility. It has also come up in the context of surgical device or equipment manufacturers who want physicians to become familiar with their products.

In general, travel expenses should not be reimbursed, nor should honoraria be paid for the visiting physician's time since the presentations are analogous to a pharmaceutical company's educational or promotional meetings. The Council recognizes that medical devices, equipment and other technologies may require, in some circumstances, special evaluation or training in proper usage which can not practicably be provided except on site. Medical specialties are in a better position to advise physicians regarding the appropriateness of reimbursement with regard to these trips. In cases where the company insists on such visits as a means of protection from liability for improper usage, physicians and their specialties should make the judgment. In no case would honoraria be appropriate and any travel expenses should be only those strictly necessary.

(b) If the company invites physicians to visit its facilities for review and comment on a product, to discuss their independent research projects or to explore the potential for collaborative research, may the company pay travel expenses and an honorarium?

If the physician is providing genuine services, reasonable compensation for time and travel expenses can be given. However, token advisory or consulting arrangements cannot be used to justify compensation.

(c) May a company hold a sweepstakes for physicians in which five entrants receive a trip to the Virgin Islands or airfare to the medical meeting of their choice?

No. The use of a sweepstakes or raffle to deliver a gift does not affect the permissibility of the gift. Since the sweepstakes is not open to the public, the guidelines apply in full force.

(d) If a company convenes a group of physicians to recruit clinical investigators or convenes a group of clinical investigators for a meeting to discuss their results, may the company pay for their travel expenses?

Expenses may be paid if the meetings serve a genuine research purpose. One guide to their propriety would be whether the NIH conducts similar meetings when it sponsors multi-center clinical trials. When travel subsidies are acceptable, the guidelines emphasize that they be used to pay only for "reasonable" expenses. The reasonableness of expenses would depend on a number of considerations. For example, meetings are likely to be problematic if overseas locations are used for exclusively domestic investigators. It would be inappropriate to pay for recreation or entertainment beyond the kind of modest hospitality described in this guideline.

(e) How can a physician tell whether there is a "genuine research purpose?"

A number of factors can be considered. Signs that a genuine research purpose exists include the facts that there are:

(1) a valid study protocol,
(2) recruitment of physicians with appropriate qualifications or expertise, and
(3) recruitment of an appropriate number of physicians in light of the number of study participants needed for statistical evaluation.

(f) May a company compensate physicians for their time and travel expenses when they participate in focus groups?

Yes. As long as the focus groups serve a genuine and exclusive research purpose and are not used for promotional purposes, physicians may be compensated for time and travel expenses. The number of physicians used in a particular focus group or in multiple focus groups should be an appropriate size to accomplish the research purpose, but no larger.

(g) Do the restrictions on travel, lodging and meals apply to educational programs run by medical schools, professional societies or other accredited organizations which are funded by industry, or do they apply only to programs developed and run by industry?

The restrictions apply to all conferences or meetings which are funded by industry. The Council drew no distinction on the basis of the organizer of the conference or meeting. The Council felt that the gift of travel expenses is too substantial even when the conference is run by a non-industry sponsor. (Industry includes all "proprietary health-related entities that might create a conflict of interest.")

(h) May company funds be used for travel expenses and honoraria for bona fide faculty at educational meetings?

This guideline draws a distinction between attendees and faculty. As was stated, "[i]t is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses."

Companies need to be mindful of the guidelines of the Accreditation Council on Continuing Medical Education. According to those guidelines, "[f]unds from a commercial source should be in the form of an educational grant made payable to the CME sponsor for the support of programming."

(i) May travel expenses be reimbursed for physicians presenting a poster or a "free paper" at a scientific conference?

Reimbursement may be accepted only by bona fide faculty. The presentation of a poster or a free paper does not by itself qualify a person as a member of the conference faculty for purposes of these guidelines.

(j) When a professional association schedules a long-range planning meeting, is it appropriate for industry to subsidize the travel expenses of the meeting participants?

The guidelines are designed to deal with gifts from industry which affect, or could appear to affect the judgment of individual practicing physicians. In general, a professional society should make its own judgment about gifts from industry to the society itself.

(k) May continuing medical education conferences be held in the Bahamas, Europe or South America?

There are no restrictions on the location of conferences as long as the attendees are paying their own travel expenses.

(l) May travel expenses be accepted by physicians who are being trained as speakers or faculty for educational conferences and meetings?
In general, no. If a physician is presenting as an independent expert at a CME event both the training and its reimbursement raise questions about independence. In addition, the training is a gift because the physician's

role is generally more analogous to that of an attendee than a participant. Speaker training sessions can be distinguished from meetings (See 5b) with leading researchers, sponsored by a company, designed primarily for an exchange of information about important developments or treatments, including the sponsor's own research, for which reimbursement for travel may be appropriate.

(m) What kinds of social events during conferences and meetings may be subsidized by industry?

Social events should satisfy three criteria. First, the value of the event to the physician should be modest. Second, the event should facilitate discussion among attendees and/or discussion between attendees and faculty. Third, the educational part of the conference should account for a substantial majority of the total time accounted for by the educational activities and social events together. Events that would be viewed (as in the succeeding question) as lavish or expensive should be avoided. But modest social activities that are not elaborate or unusual are permissible, e.g., inexpensive boat rides, barbecues, entertainment that draws on the local performers. In general, any such events which are a part of the conference program should be open to all registrants.

(n) May a company rent an expensive entertainment complex for a evening during a medical conference and invite the physicians attending the conference?

No. The guidelines permit only modest hospitality.

(o) If physicians attending a conference engage in interactive exchange, may their travel expenses be paid by industry?

No. Mere interactive exchange would not constitute genuine consulting services.

(p) If a company schedules a conference and provides meals for the attendees that fall within the guidelines, may the company also pay for the costs of the meals for spouses?

If a meal falls within the guidelines, then the physician's spouse may be included.

(q) May companies donate funds to sponsor a professional society's charity golf tournament?

Yes. But it is sensible if physicians who play in the tournament make some contribution themselves to the event.

(r) If a company invites a group of consultants to a meeting and a consultant brings a spouse, may the company pay the costs of lodging or meals of the spouse? Does it matter if the meal is part of the program for the consultants?

Since the costs of having a spouse share a hotel room or join a modest meal are nominal, it is permissible for the company to subsidize those costs. However, if the total subsidies become substantial, then they become unacceptable.

Guideline 6

Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional or specialty medical associations.

(a) When a company subsidizes the travel expenses of residents to an appropriately selected conference, may the residents receive the subsidy directly from the company?

Funds for scholarships or other special funds should be given to the academic departments or the accredited sponsor of the conference. The disbursement of funds can then be made by the departments or the conference sponsor.

(b) What is meant by "carefully selected educational conferences?"

The intent of Guideline 6 is to ensure that financial hardship does not prevent students, residents and fellows from attending major educational conferences. For example, we did not want to deny cardiology fellows the

opportunity to attend the annual scientific meeting of the American College of Cardiology or orthopedic surgery residents the opportunity to attend the annual scientific meeting of the American Academy of Orthopedic Surgeons. However, it was not the intent of the guideline to permit reimbursement of travel expenses in other circumstances, such as when conferences or symposia are designed specifically for students, residents or fellows.

Accordingly, "carefully selected educational conferences" should be interpreted as follows: funds may be used for the reasonable travel and lodging expenses of students, residents and fellows to attend the major educational, scientific or policymaking meetings of national, regional or specialty medical associations.

The Council recognizes that there may be some exceptional conferences for all physicians or even for just students, residents, or fellows that do not fall within this definition of carefully selected educational conferences but that meet the spirit of Guideline 6. Accordingly, the Council will consider proposals for travel and lodging subsidies for such conferences on a case-by-case basis and grant approval to those that meet the spirit of the guidelines.

Guideline 7

No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician's prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should belong to the organizers of the conferences or lectures.

(a) May companies send their top prescribers, purchasers, or referrers on cruises?

No. There can be no link between prescribing or referring patterns and gifts. In addition, travel expenses, including cruises, are not permissible.

(b) May the funding company itself develop the complete educational program that is sponsored by an accredited continuing medical education sponsor?

No. The funding company may finance the development of the program through its grant to the sponsor, but the accredited sponsor must have
responsibility and control over the content and faculty of conferences, meetings, or lectures. Neither the funding company nor an independent
consulting firm should develop the complete educational program for approval by the accredited sponsor.

(c) How much input may a funding company have in the development of a conference, meeting, or lectures?

The guidelines of the Accreditation Council on Continuing Medical Education on commercial support of continuing medical education address this question. Issued 1992. Updated December 2000 and June 2002, and June 2004 (*Food and Drug Law Journal*, 2001; 56(1):27-40).

(HP)

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

Health Facility Ownership by Physicians
Physicians' Self-Referral

The Massachusetts Medical Society (MMS) adopts the American Medical Association Council on Ethical and Judicial Affairs Opinion E-8.0321, "Physicians' Self-Referral," which reads as follows:

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

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

responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.
(2) Ensure that the arrangement:
(a) is structured to enhance access to appropriate, high quality health care services or products; and
(b) within the constraints of applicable law:
(i) does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
(ii) does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
(iii) adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(3) Take steps to mitigate conflicts of interest, including:
(a) ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products;
(b) establishing mechanisms for utilization review to monitor referral practices; and
(c) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral. (II, III, VIII)

Issued June 2009 based on the report "Physicians' Self-Referral," adopted November 2008.
(HP)

MMS House of Delegates, 5/17/14
(Previous Policy Amended)

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

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

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

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

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

MMS House of Delegates, 5/17/14

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

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

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

Principles of Medical Ethics:

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

(HP)

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

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

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

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

Notification of Physician Departure

The Massachusetts Medical Society adopts the following principles relating to Patient Notification Upon Departure of a Physician from a Practice:

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

If the departing physician will be available to continue to provide care to said patient, the notification letter must include the departing physician's forwarding address and telephone number.
Absent an agreement to the contrary, the custodian of the medical record is responsible for patient notification.

The Massachusetts Medical Society considers it unethical to withhold said patient notification.

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

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

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

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

MMS House of Delegates, 11/19/94
Reaffirmed MMS House of Delegates, 5/11/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08)

Patient Testimonials
The Massachusetts Medical Society adopts the following policy, adapted from the American Medical Association Council on Ethical and Judicial Affairs Opinion E-5.02, "Advertising and Publicity," updated June 1996, which reads as follows:

There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

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

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

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

Any financial, business, or other relationship between the testimoniant and the physician should be fully disclosed.

Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable.

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

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

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

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

MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15

End-of-Life Care *(Please See Additional Policy under Medical Education)*
The MMS will conduct a membership survey to determine attitudes of physicians and physicians-in-training in Massachusetts toward medical aid-in-dying with a report back to the MMS House of Delegates at A-17. *(D)*
MMS House of Delegates, 12/3/16

The Massachusetts Medical Society supports the following principles for the provision of comprehensive care for individuals with advanced serious illness who are nearing the end of life:

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

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

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

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

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

The MMS advise physician members and the public, via existing communication venues, on legislative issues that may affect access to person-centered, family-oriented care that enhances autonomy and choice at the end of life. *(D)*

MMS House of Delegates, 12/6/14

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

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

The Massachusetts Medical Society is opposed to physician-assisted suicide. *(HP)*

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 12/3/11

The Massachusetts Medical Society recognizes the autonomy rights of terminally ill and/or vegetative individuals who have previously expressed their wishes to refuse treatment including the use of intravenous fluids and gastrointestinal feeding by tube and that implementation of these wishes by a physician does not in itself constitute unethical medical behavior provided that appropriate medical and family consultation is obtained.

MMS Council, 7/17/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Referrals

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

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

Sale of Health-Related Products from Physicians' Offices

The Massachusetts Medical Society (MMS) endorses Section E-8.063 of the American Medical Association Code of Ethics, "Sales of Health-Related Products from Physicians' Offices," issued June 1999, which reads as follows:

"Health-related products" are any products that, according to the manufacturer or distributor, benefit health. "Selling" refers to the activity of dispensing items that are provided from the physician's office in exchange for money and also includes the activity of endorsing a product that the patient may order or purchase elsewhere that results in direct remuneration for the physician. This Opinion does not apply to the sale of prescription items, which is already addressed in Opinion 8.06, "Prescribing and Dispensing Drugs and Devices." Physicians who engage in in-office sales practices should be aware of the related guidelines presented in Opinion 8.062, "Sale of Non-Health-Related Goods from Physicians' Offices"; Opinion 8.06, "Prescribing and Dispensing Drugs and Devices"; Opinion 8.032, "Conflicts of Interest: Health Facility Ownership by a Physician"; Opinion 3.01, "Nonscientific Practitioners"; and Opinion 8.20, "Invalid Medical Treatment"; as well as the reports from which these opinions are extracted. In-office sale of health-related products by physicians presents a financial conflict of interest, risks placing undue pressure on the patient, and threatens to erode patient trust and undermine the primary obligation of physicians to serve the interests of their patients before their own.

1. Physicians who choose to sell health-related products from their offices should not sell any health-related products whose claims of benefit lack scientific validity. When judging the efficacy of a product, physicians should rely on peer-reviewed literature and other unbiased scientific sources that review evidence in a sound, systematic, and reliable fashion.
2. Because of the risk of patient exploitation and the potential to demean the profession of medicine, physicians who choose to sell health-related products from their offices must take steps to minimize their financial conflicts of interest. The following guidelines apply:
    a. In general, physicians should limit sales to products that serve the immediate and pressing needs of their patients. For example, if traveling to the closest pharmacy would in some way jeopardize the welfare of the patient (e.g., forcing a patient with a broken leg to travel to a local pharmacy for crutches), then it may be appropriate to provide the product from the physician's office. These conditions are explained in more detail in the Council's Opinion 8.06, "Prescribing and Dispensing Drugs and Devices," and are analogous to situations that constitute exceptions to the permissibility of self-referral.
    b. Physicians may distribute other health-related products to their patients free of charge or at cost, in order to make useful products readily available to their patients. When health-related products are offered free or at cost, it helps to ensure removal of the elements of personal gain and financial conflicts of interest that may interfere, or appear to interfere, with the physician's independent medical judgment.
3. Physicians must disclose fully the nature of their financial arrangement with a manufacturer or supplier to sell health-related products. Disclosure includes informing patients of financial interests as well as about the availability of the product or other equivalent products elsewhere. Disclosure can be accomplished through face-to-face communication or by posting an easily understandable written notification in a prominent location that is accessible by all patients in the office. In addition,

physicians should, upon request, provide patients with understandable literature that relies on scientific standards in addressing the risks, benefits, and limits of knowledge regarding the health-related product.

4. Physicians should not participate in exclusive distributorships of health-related products that are available only through physicians' offices. Physicians should encourage manufacturers to make products of established benefit more fairly and more widely accessible to patients than exclusive distribution mechanisms allow. (II)

The MMS adopts the clarification of Opinions 8.063, "Sale of Health-Related Goods from Physician Offices," adopted December 2000, which reads as follows:

The physician who provides or sells products to patients must follow the above guidelines regardless of whether the products are provided in the physician's office or through a practice website.
(HP)

MMS House of Delegates, 12/3/05
Reaffirmed MMS House of Delegates, 5/19/12

Sexual Harassment/Misconduct

The Massachusetts Medical Society unequivocally disapproves and rejects any and all forms of sexual harassment.

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

The Massachusetts Medical Society considers sexual misconduct of physicians with patients to be unethical. While physicians have a constitutional right of freedom of association, they must not use their role as physicians in an exploitative manner.

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

Stem Cell Research – Federal Funding of

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

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

Firearms: Safety and Regulation

Assault Weapons

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

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

Handguns

1. The MMS is guided by the principles of reducing the number of deaths, disabilities, and injuries attributable to guns; making gun ownership safer; promoting education relative to guns, ammunition, and violence prevention, for physicians and other health professionals as well as for the public; encouraging research to understand the risk factors related to gun violence and deaths. *(HP)*

2. The MMS encourages health care providers to review gun safety as a routine component of preventive care. *(D)*

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

4. The MMS strongly advocates that the AMA support federal efforts to promote legislation to make licensing and background checks mandatory for all sales of firearms regardless of seller. *(D)*

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

6. The MMS will offer education to physicians and other health care providers concerning instituting a gun safety discussion. *(D)*

7. That the MMS initiate a campaign within the framework of the Society's existing publications and communications, on behalf of the public's health, to diminish the menace of gun violence in America and beyond. *(D)*

MMS House of Delegates, 5/11/13

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

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

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

MMS House of Delegates, 5/21/11

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.
3. The Massachusetts Medical Society supports education of the general public about the inherent dangers of guns and gun safety measures and precautions.

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.
2. [The MMS] encourages physicians to broaden medical evaluations to include a screening for risk of harm

from access to firearms.

3. The Massachusetts Medical Society supports efforts to educate licensed firearms dealers on the health implications of firearm injuries and violence.
4. The Massachusetts Medical Society supports education of the general public about the epidemic of gun violence by urging that the Massachusetts Department of Public Health be funded to undertake a comprehensive, statewide, multimedia public information campaign.
5. The Massachusetts Medical Society supports the education of physicians and other healthcare providers, families, and communities, regarding the importance of reducing and limiting violent media programming for entertainment purposes (movies, TV, video, radio, etc.) when children are viewing.

Collaboration

1. The Massachusetts Medical Society supports laws, regulations, and policies that would require firearm manufacturers to invest in ongoing efforts to improve safety technologies.
2. The Massachusetts Medical Society supports measures requiring gun manufacturers to engineer childproofed handguns.
3. The Massachusetts Medical Society supports measures requiring that guns must pass minimum safety standards and not be made of inferior materials, not be prone to firing based on a single pull of the trigger, not be prone to the explosion of the handgun during firing with standard ammunition, and not be prone to accidental discharge.
4. The Massachusetts Medical Society supports the ongoing review of what is considered "minimum safety standards" in light of improving safety technologies.
5. The Massachusetts Medical Society supports the continued ban on the sale of small, inexpensive, and poorly manufactured junk guns.
6. The Massachusetts Medical Society supports the imposition of a tax on all firearm sales, new or used, with revenue directed toward public education regarding firearm safety.
7. The Massachusetts Medical Society supports continued efforts to strengthen the dealer licensing system requiring that ammunition be sold only through licensed dealers, and that it only be sold to licensed holders.
8. The Massachusetts Medical Society supports the prohibition of firearm ownership by convicted felons.
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.
11. The Massachusetts Medical Society supports halting the sale and manufacture of lethal types of ammunition that have no use in hunting game or sports.
12. The Massachusetts Medical Society joins with other organizations working to reduce gun violence, to increase the efficiency of our advocacy on issues for which we share common policies.

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

Health Care Delivery

Accountable Care Organizations

The Massachusetts Medical Society will advocate for legislation or regulation that would prohibit or render unenforceable any ACO or integrated network, *network-to-physician* contract terms that require physician participation in all risk contracts held by that network, and prohibit or render unenforceable contract terms that specifically require physicians to contract exclusively with one particular network. *(D)*

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society work with appropriate stakeholders to advocate for legislation or regulations that will enable specialist physicians to participate as "primary" members of more than one Accountable Care Organization (ACO) without having to create a new legal entity with a separate tax ID number. *(D)*

MMS House of Delegates, 12/6/14

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

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

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

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

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

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

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

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

7. Governance: In accordance with AMA principles on ACOs, physicians who participate in an ACO or an IDN should make medical decisions that are not based on commercial interests, but rather on professional medical judgment that puts patients' interests first. This should be a clear mandate from all parties involved. Physician participation in ACO governance is key to the success of the ACO, and as such, physicians should be aware of board membership roles and responsibilities. Ensuring the option for such participation is an important decision point. Given the responsibility, detailed governance-based roles should be clearly outlined and communicated to ACO participants up front.

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

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

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

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

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

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

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

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

(HP)

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

The MMS will strongly advocate that all physicians practicing in the same geographic area be allowed to participate in any local accountable care organizations or integrated networks upon demonstration of compliance with non-exclusionary transparent requirements for participation. *(D)*

The MMS will advocate that a physician's participation in one ACO should not disqualify the physician from participation in another ACO. *(D)*

MMS House of Delegates, 5/19/12
(Item 3 of Original: Sunset)

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.

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

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

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

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

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

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

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

5. Flexibility in patient referral and antitrust laws. The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

    The AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. The AMA will provide information to members regarding AMA vetted legal and financial advisors, and will seek discount fees for such services.

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

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

MMS House of Delegates, 5/19/12

Care for Military Casualties

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

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

Certificate of Need

The MMS will propose legislation and/or regulations to allow for greater availability of health care services currently covered by Certificate of Need requirements. *(D)*

MMS House of Delegates, 5/7/16

Clinical Integration

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

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

MMS House of Delegates, 5/21/11

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

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

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

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

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

That the MMS dedicate Monday, March 30, 2015, known as Doctor's Day, to the recognition of the basic principles of confidentiality and free speech in the doctor-patient relationship. *(D)*

MMS House of Delegates, 12/6/14

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

MMS House of Delegates, 5/14/10

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

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

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

Physician Services
The Massachusetts Medical Society will do everything possible to strengthen the determination of all of its physicians, including those under salary with managed care entities, to retain the power to make proper medical decisions for their patients and the public in general.

MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/08

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

MMS House of Delegates, 12/5/15

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

MMS House of Delegates, 12/1/12

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

MMS House of Delegates, 12/3/16

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

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

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

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

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

(HP)

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

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

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

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

MMS House of Delegates, 11/15/08
Amended and Reaffirmed MMS House of Delegates, 5/7/16

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

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

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

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14

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

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

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

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

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

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

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

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

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

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

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

MMS House of Delegates, 5/11/13

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

MMS House of Delegates, 12/3/16

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

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

The Massachusetts Medical Society (MMS) considers that the primary goals in the application and development of telemedicine are the promotion of the patients' best interests, quality of care, and the preservation of an optimal patient-physician relationship.

The MMS shall work with the Massachusetts Board of Registration in Medicine (BRM) in its efforts to specify the appropriate practice of telemedicine.

The MMS urges that legislation be developed to effect the safe practice of telemedicine within and outside Massachusetts.

Legislation to effect the safe practice of telemedicine shall include mechanisms to promote the appropriate practice of medicine across state lines.

Legislation to effect the safe practice of telemedicine shall provide for simplification of the certification process to practice medicine across state lines.

The MMS requests that the BRM and the Massachusetts Board of Registration in Pharmacy review current practices of prescribing medications across state lines.

The MMS requests that the BRM establish and strengthen liaison with contiguous and nearby states for the purpose of furthering the appropriate use of telemedicine.

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

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

MMS House of Delegates, 11/6/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Amended and Reaffirmed MMS House of Delegates, 5/7/16

Telemedicine is defined as the use of telecommunications technologies over distance (including, but not limited to, telephone, wire, facsimile machine, computers, satellites, fiber optics, lasers, television, robotics, virtual imaging) in the application of health care delivery, diagnosis, treatment, triage, information, and data transfer, consultation and medical education among patients, physicians, other providers, organizations, and governments. *(HP)*

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society affirms that any physician practicing telemedicine with a patient in Massachusetts should possess a full and unrestricted license in Massachusetts.

MMS House of Delegates, 11/21/97
Reaffirmed, MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Treatment Variations
The Massachusetts Medical Society will cooperate with other institutions and agencies who are committed to explore the validity, causes, meaning, and long term significance of treatment variations in surgical and medical practices as identified in studies using population based data.

MMS Council, 5/20/89
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Workers' Compensation Coverage
The Massachusetts Medical Society supports legislative efforts to ensure provision of written information to temporary workers within 72 hours or fewer of hire detailing required personal protective equipment for the job and all information necessary to access workers' compensation benefits in the event of a workplace injury. *(HP)*

MMS House of Delegates, 5/21/11

The Massachusetts Medical Society (MMS) encourages maximum workplace safety for all workers. *(HP)*

The MMS supports efforts to increase access to workers' compensation coverage for all workers, including immigrant workers, as provided for by Massachusetts law. *(HP)*

The MMS will promote awareness among Massachusetts health care providers of workers' compensation coverage for immigrant workers. *(D)*

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

HEALTH EDUCATION

Student Health
The MMS encourages local communities to provide comprehensive health education to students that incorporates information on the prevention of STIs, including HIV. *(D)*

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

Translation of Patient Education Material
The Massachusetts Medical Society (MMS) provide for the professional translation of patient education materials developed by the Society in one or more non-English versions, in order to meet significant unmet community needs. *(D)*

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/17/14

HEALTH INSURANCE/MANAGED CARE PLANS

Administrative Costs
The Massachusetts Medical Society believes that, unless otherwise required by law, physicians should be paid a reasonable fee for the preparation of reports, copying, and postage when asked to provide information to third parties.

Physicians shall continue to comply with the requirement to provide copies of medical records to the patient according to state law.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

That the MMS pursue the development of an adjunct set of financial data collection forms for Massachusetts health plans, modeled after the Minnesota Health Plan Financial Statistical Report, that provides specific expense itemizations, and that following the development of these collection forms, the MMS consider pursuing legislation to require all insurers to adhere to these reporting requirements on an annual basis. *(D)*

MMS House of Delegates 11/3/07
Amended and Reaffirmed MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

Antitrust/Anticompetitive Markets
The Massachusetts Medical Society adopts the following adapted from an American Medical Association directive:

> That the Massachusetts Medical Society work locally and with national stakeholders to monitor and oppose consolidation in the health insurance industry, given that it may result in anticompetitive markets. *(D)*

MMS House of Delegates, 5/7/16

The Massachusetts Medical Society (MMS) supports state and federal solutions to antitrust issues; and that the MMS continue efforts aimed at easing practice constraints on physicians engendered by Managed Care Plans.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society supports legislation in the United States Congress that would allow physicians as a group to negotiate without fear of antitrust violation with payers, such as insurance companies, HMOs, and managed care companies on the terms of physicians' contracts, such as payment rates, clinical decision-making and administrative responsibilities.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Coverage Decisions
The Massachusetts Medical Society adopts the following Principles for Health Plan Coverage Decisions:

I. Health plan processes for designing and determining health plan coverage decisions should be:

- Evidence based
- Transparent
- Participatory
- Equitable and Consistent
- Sensitive to Value
- Compassionate

II. Health plan processes for designing and determining health plan coverage decisions should:

a. Assure that the health plan's clinical policies and treatment approval decisions are responsive to patient concerns.

   i. Physicians and patients should have access to the clinical guidelines for all health plans in which they participate via websites and/or written materials.
   ii. All clinical policies should be based on the best available evidence.

b. Establish physician advisory groups through which physicians participating in the plan's network can provide input into the health plan's policies affecting coverage decisions.

   i. Health plans should be transparent as to who serves on the advisory group.
   ii. Advisory groups should include practicing physicians with the appropriate expertise.

c. Include health plan members in decision-making at the appropriate organizational level regarding policies and processes that affect patient care and allocation of clinical resources.

   i. Provide employers, health plan members and participating physicians with the criteria and process used for determining when new technologies and procedures become a covered benefit.
   ii. Explicitly describe those services it will not currently cover because they are deemed to be "experimental."

d. Be based on best available scientific evidence, in the context of treatment expense.

e. Involve physicians and health plan members in appeals regarding treatment authorizations. Ensure physicians have the right to appeal adverse coverage decisions. Health plans should have in place systems to review and process physician appeals when appropriate.

f. Respond to requests for prior authorization of a non-emergency service, upon receipt of complete information, within a reasonably pre-determined time frame.

g. Identify information that health plan members want and need regarding the plan's process for making coverage decisions.

h. Provide easy access for all stakeholders to information about the health plan's decision-making processes in language that is easily comprehensible.

(HP)

MMS House of Delegates, 12/1/12

Differential Copayments
The Massachusetts Medical Society (MMS) does not, at this time, support differential copayments for primary care and specialist office visits because of concerns expressed about potential unintended consequences, including access to and quality of care.

The MMS will educate the public about the unintended consequences of differential copayments for primary care and specialist office visits.

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

Fee Schedules
The MMS will advocate for and affirm that the third-party payer shall release to the participating physician practice said practice's fee schedule within two business days of a written or documented phone request. *(D)*

MMS House of Delegates, 12/3/16

Financial Incentives
The Massachusetts Medical Society, in addition to its policies on Financial Incentives and policy document entitled Ethical Standards in Managed Care, will pursue federal and state legislative remedies which will add more safeguards to limit financial risk arrangements that might impinge on the quality of patient care and the financial viability of physician practices. *(D)*

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

It shall be the policy of the MMS that health plans should not establish financial incentives or quotas that interfere with clinical judgment such as limiting diagnostic tests, services, referrals, or access to care.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Health Insurance
Individual Choice and Support for a Pluralistic System

1. The Massachusetts Medical Society (MMS) supports the availability of a choice of health care financing mechanisms.

2. The MMS supports a wide choice of health care plans and call for a uniform employer contribution toward the employee's health expense coverage, regardless of the plan chosen, where the employer contributes to health plan costs.

3. The MMS calls for free market competition among all modes of health care delivery and financing, with the growth of any one system determined by popular preference and not preferential regulation or subsidy.

4. The MMS supports and advocates a health care financing system where individually purchased and owned health expense coverage is the preferred option, but where employer-provided coverage is still available to the extent the market demands it.

Change in Tax Treatment

5. MMS policy will express a preference for replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with a tax credit for individuals and families.

6. The MMS will express a preference for relating the individual tax credit for all health expense coverage expenditures by individuals and/or their employers to the individual's income, rather than being a uniform percentage of such expenditures.

7. The MMS supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for total employer-purchased coverage.

Voluntary Choice Cooperatives

8. The MMS supports the American Medical Association (AMA) as it seeks legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed.

9. The MMS, through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches, and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope.

Defined Contribution

10. The MMS endorses the concept that employers provide a defined contribution for the purchase of health expense coverage within the private sector for all full-time employees.

Supporting Transitory Populations

11. The MMS supports the AMA as it seeks legislation requiring a "maintenance of effort" period, such as one or two years, during which time employers would be required to add to the employee's salary the cash value of any health expense coverage they directly provide if they discontinue that coverage, or if the employee opts out of the employer-provided plan.

Risk Adjustment

12. The MMS encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased health expense coverage where useful risk-adjustment measures, such as age, sex, and family status, would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one.

13. The MMS encourages continued experimentation with, and monitor the success of, approaches to minimizing or compensating for adverse selection among the individually purchased and owned health expense plans available, including risk adjustment across plans, reinsurance pools, and limiting enrollment and disenrollment opportunities through such mechanisms as multi-year policy contracts.

Community Rating Bands

14. The MMS supports the AMA as it encourages state medical associations to seek the introduction or support of legislation requiring the use of community rating bands in the individual health expense coverage plans made available under provisions of the Health Insurance Portability and Accountability Act of 1996 (PL 104-191) in all states presently without rating restrictions on such individual coverage plans.

Preference for Tax Incentives vs. Compulsory Approach

15. The MMS supports strong tax incentives, such as making tax credits contingent on purchase of a specified minimum level of coverage, as opposed to compulsory approaches, to encourage individuals to obtain coverage providing a specified minimum level of protection against out-of-pocket expense for health services and incorporating provisions of the AMA Patient Protection Act, whether through a traditional insurance or managed care plan or a medical savings account.

Education

16. The MMS strongly encourages, through all appropriate channels, the development of educational programs to assist consumers in making informed choices concerning sources of individual health expense coverage.

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

The Massachusetts Medical Society supports an individual's right to select, purchase, and own his/her health insurance and to receive similar tax treatment for individually purchased insurance as for employer purchased coverage.

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

Hospice Care/Benefits

The MMS will advocate for legislation or regulation to provide a hospice benefit to all patients under MA public health insurance plans. *(D)*

MMS House of Delegates, 5/11/13

HPV Vaccine

The Massachusetts Medical Society will advocate that insurance companies cover human papillomavirus vaccine for all patients for whom there is a vaccination recommendation from the Advisory Committee on Immunization Practices (ACIP). *(D)*

MMS House of Delegates, 5/14/10

Increased Cost-Sharing: Study

The MMS, in order to devise advocacy regarding plans with increased cost-sharing (including, but not limited to, copayments, co-insurance, high-deductibles, and other out-of-pocket expenses), shall research and explore standards for improving patient education and policies regarding out-of-pocket costs for preventive and diagnostic services in these health plans. *(D)*

The MMS, in order to devise advocacy regarding plans with increased cost-sharing (including, but not limited to, copayments, co-insurance, high-deductibles, and other out-of-pocket expenses) shall research and explore health care delivery systems, cost transparency, and payment models for these health plans, in order to (a) improve the ability to collect patient payments and (b) engage patient compliance with necessary medical care. *(D)*

MMS House of Delegates, 5/7/16

Informing Patients' Regarding Health Care Costs
The MMS takes the position that those who set rates of reimbursement are responsible for informing patients of their anticipated health care costs. *(HP)*

The MMS actively oppose any requirements that a physician inform patients of their anticipated total health care costs. *(D)*

MMS House of Delegates, 12/1/12

Insurance Reform
The Massachusetts Medical Society encourages the expansion of the concept of Medical Savings Accounts.

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14

Managed Care Resources & Education
The MMS adopts the following principles:

1. All consumer information from insurers should be made available though a wide array of media, including but not limited to print (e.g., brochures and advertisements) and internet-based materials.
2. Consumer information should be presented in a clear and concise manner at a sixth-grade reading level, and should include additional levels of information (e.g., increasingly complex information, such as at a twelfth-grade or college reading level) at the consumer's preference.
3. Examples and anecdotal information should be provided in consumer information materials, as appropriate, to make the information as relevant for the consumer as possible.
4. Consumers should be active participants in the development of the resources (e.g., pre- and post-test) to provide insurers with feedback on the level and quality of the information.
5. Consumer information should be made available in a wide variety of languages based on the diverse composition of the population.

(HP)

MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15

The Massachusetts Medical Society will review existing state statutes, state regulations and policies concerning timely payment by third party payers, disseminate this information to the membership and, where appropriate, file legislation to enhance timely payment of claims including the provision of penalties and interest.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Physician Budgets/Withholds
The Massachusetts Medical Society (MMS) shall seek an appropriate legislative opportunity to mandate that managed care organizations in determining physician budget amounts will not include any of the managed care organization's costs including reinsurance costs and or subrogation of claims.

The MMS shall seek an appropriate legislative opportunity to mandate that managed care organizations that take withholds be required to pay a reasonable rate of interest on withhold payments that are returned.

The MMS shall propose legislation requiring insurance companies to extract claims that may involve other carriers or future settlements, such as auto accidents involving legal cases, from year-end budget and settlement information.

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates, 5/9/0
Reaffirmed MMS House of Delegates, 5/2/15

Radiology Co-Payments
The MMS officers and staff will continue to monitor the impact of health plans' use of co-payments for radiology studies that could limit patient access, and when appropriate, advocate for modified co-payments when they are in the best interest of patients. *(HP)*

MMS House of Delegates, 5/9/08
Amended and Reaffirmed MMS House of Delegates, 5/2/15

Value-Based Insurance Design
The MMS will monitor third-party payers who use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. *[D]*

The MMS supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles:

a. Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
b. Practicing physicians should be actively involved in the development of VBID programs.
c. High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan.
d. The methodology and criteria used to determine high- or low-value services or treatments must be transparent and easily accessible to physicians and patients.
e. Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design.
f. VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. Where feasible and appropriate, VBID should take patient preferences into account.
g. Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties.
h. Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence.

(HP)

MMS House of Delegates, 12/7/13

The MMS will advocate that the AMA study value-based insurance design, its impact on the physician workforce and patient access. *(D)*

MMS House of Delegates, 12/3/11

HEALTH SYSTEM REFORM

The Massachusetts Medical Society adopts the following Principles for Health Care Reform:

1. *Physician leadership*. Physician leadership is seen as essential for the implementation of new payment reform models. Strong leadership from primary care and specialty care physicians in both the administrative structure of accountable care organizations (ACOs) and other payment reform models, as well as in policy development, cost containment and clinical decision-making processes, is key.

2. *One size will not fit all*. One single payment model will not be successful in all types of practice settings. Many physician groups will have a great deal of difficulty making a transition due to their geographic location, patient mix, specialty, technical and organizational readiness, and other factors.
3. *Deliberate and careful*. Efforts must be undertaken to guard against the risk of unintended consequences in any introduction of a new payment system.

4. *Fee-for-service payments have a role*. While a global payment model could encourage collaboration among providers, care coordination, and a more holistic approach to a patient's care, fee-for-service payments should be a component of any payment system.

5. *Infrastructure support*. Sufficient resources for a comprehensive health information technology infrastructure and hiring an appropriate team of physician assistants, nurse practitioners, and other relevant staff are essential across all payment reform models.

6. *Proper risk adjustment*. In order to take on a bundled, global payment or other related payment models, funding must be adequate, and adequate risk adjustment for patient panel sickness, socioeconomic status, and other factors is needed. Current risk adjustment tools have limitations, and payers must include physician input as tools evolve and provide enough flexibility regarding resources in order to ensure responsible approaches are implemented. In addition, ACOs and like entities must have the infrastructure in place and individuals with the skills to understand and manage risk.

7. *Transparency*. There must be transparency across all aspects of administrative, legal, measurement, and payment policies across payers regarding ACO structures and new payment models. There must also be transparency in the financing of physicians across specialties. Trust is a necessary ingredient of a successful ACO or other payment reform model. The negotiations between specialists, primary care physicians, and payers will be a determining factor in establishing this trust.

8. *Proper measurements and good data*. Comprehensive and actionable data from payers regarding the true risks of patients is key to any payment reform model. Without meaningful, comprehensive data, it becomes impractical to take on risk. Nationally accepted, reliable, and validated clinical measures must be used to both measure quality performance and efficiency and evaluate patient experience. Data must be accurate, timely, and made available to physicians for both trending and the ability to implement quality improvement and cost effective care. The ability to correct inaccurate data is also important.

9. *Patient expectations*. Patient expectations need to be realigned to support the more realistic understanding of benefits and risks of tests and clinical services or procedures when considering new payment reform models. Physicians and payers must work together to provide a public health educational campaign, with an opportunity for patients to provide input as appropriate and engage in relevant processes.

10. *Patient incentives*. Patient accountability coupled with physician accountability will be an effective element for success with payment reform. An important aspect of benefit design by payers is to exclude cost sharing for preventive care and other selected services.

11. *Benefit design*. Benefit designs should be fluid and innovative. Any contemplation of regulation and legislation with regard to benefit design should balance mandating minimum benefits, administrative simplification, with sufficient freedom to create positive transparent incentives for both patients and physicians to maximize quality and value.

12. *Professional liability reform*. Defensive medicine is not in the patient's best interest and increases the cost of healthcare. In an environment where physicians have the incentive to do less, but patients request more, physicians view litigation as an inevitable outcome unless there is effective professional liability reform.

13. *Antitrust reform*. As large provider entities, ACO definitions and behavior may collide with anti-trust laws. The state legislature may be the adjudicator of antitrust issues. Accountable care organizations and other relevant payment reform models should be adequately protected from existing antitrust, gain-sharing, and similar laws that currently restrict the ability of providers to coordinate care and collaborate on payment models.

14. *Administrative simplification*. Physicians and others who participate in new payment models, including ACOs, should work with payers to reduce administrative processes and complexities and related burdens that interfere with delivering care. Primary care physicians should be protected from undue administrative burdens or should be appropriately compensated for it.
15. *The incentives to transition*. In order to transition to a new model, incentives must be predominantly positive.

16. *Planning must be flexible*. Accommodations must be made to take into account the highly variable readiness of practices to move to a new system.

17. *Primary care physician.* All patients should be encouraged to have a primary care physician with whom they can build a trusted relationship and from whom they can receive care coordination.

18. *Patient access.* Health care reform must enable patient choice in access to physicians, hospitals and other services while recognizing economic realities.

(HP)

MMS House of Delegates, 5/21/11

Fee-for-Service
The MMS recognizes that fee-for-service and private practice medicine can be efficient, ethical, and high quality medical care, with a long tradition of patient-centered care and cost-effective care which keeps patients at the center of treatment decisions. *(HP)*

The MMS, when advocating for system reform, enthusiastically advocates for preserving the viability of a private practice option, for the benefit of patients and our members. *(D)*

MMS House of Delegates, 12/1/12

Health Care Costs
The MMS adopts principles for spending of finite health care dollars that include, but are not limited to, the following:

1. Recommendations about how best to spend limited health care dollars should be made based on the best available evidence regarding cost-effective application of resources as reviewed by a committee of representative physicians, residents of Massachusetts, and others with the expertise necessary to make these recommendations.
2. The committee's recommendations should be free from any financial conflict of interest or political influence.
3. The plan for development of recommendations must include a robust feedback process that includes frequent review of all guidelines and a timely, individual grievance process.
4. All deliberations of the committee reviewing and developing the recommendations should be transparent and open to public scrutiny.
5. In order to promote physicians' adoption of guideline recommendations designed to minimize defensive medicine, maintain quality, and reduce health care costs, malpractice reform is necessary.

(HP)

MMS House of Delegates, 12/4/10

The Massachusetts Medical Society (MMS) acknowledges the unsustainable escalation of health care costs. *(HP)*

The MMS will partner with other stakeholders to address system-wide mechanisms to control the forces responsible for the escalation in health care costs. These include among others:

a. improving the market structure for medical services through transparency of price and outcomes
b. encouraging the development of guidelines in diagnosis and treatment of conditions where evidence-based approaches are not yet available
c. suggesting insurance reform mechanisms to reduce consumer purchase of marginally-useful service, likely through higher copayment for such services

The MMS encourages a pluralistic compensation system to include fee-for-service, salary, and limited pilot studies that utilize global payment system. *(D)*

The MMS acknowledges that the fee-for-service system has positive value in the-payment for medical services. *(HP)*
The MMS will continue its strong support for medical liability reform to reduce the waste resulting from over utilization resulting from defensive medicine. *(HP)*

MMS House of Delegates, 5/14/10

The practice of defensive medicine is a contributor to rising health care costs and liability reform should be a priority in health care reform legislation. *(HP)*

MMS House of Delegates, 12/5/09
Amended and Reaffirmed MMS House of Delegates, 5/7/16

The MMS will advocate that local health plans reimburse cognitive services at a level commensurate with the expertise and time required for these services. *(D)*

The MMS maintains opposition to the federal budget neutrality/sustained growth rate policy, which reduces physician payments to reduce overall national health care expenditures. *(HP)*

The MMS will periodically explore and evaluate the progress of alternative payment models and methodologies, as well as opportunities for physician participation in these model programs, with an annual report to the membership. *(D)*

MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 1, 2, 5, and 6 of Original: Sunset)

Ideal Payer System
The Massachusetts Medical Society (MMS) defines an ideal payer system and the definition encompasses goals that include:

- universal coverage of population;
- coverage of preexisting conditions;
- accessibility to everyone regardless of location or background;
- portability for all medically necessary services; and

The MMS definition of an ideal payer system encompasses comprehensive services, that include:

- acute and chronic illness care;
- prevention of disease and disability by risk assessment and education to change behaviors that may lead to disease or injury, early disease detection and treatment: to prevent, diminish, compress, and delay its disablements;
- rehabilitation of disabled persons: to improve their function for work and living;
- immunization;
- counseling;
- unimpeded access to appropriate specialty and subspecialty care; and

The MMS definition of an ideal payer system encompasses qualities, that include:

- efficiency/cost-effectiveness;
- equity/fairness, convenience and satisfying;
- maximal patient and physician involvement, choice, mutual decision-making, and respect;
- use of appropriate technologies, scientifically assessed for the needs of patients;
- continuous improvement efforts for better health care;
- outcomes through: practitioner education, at the undergraduate, graduate, and continuing medical education levels;
- research;
- reorganization of processes of care;
- professional self-management, internal to the practice;
- voluntary participation of physicians and patients;
- maintain freedom of physicians to contract directly with their patients;
- individuals retain right to establish medical saving accounts and to purchase catastrophic health insurance from insurer's of their choice
- maintain freedom of entry into the health insurance market; and

The MMS definition of an ideal payer system encompasses characteristics for payment of services and insurance, that include:

- simplicity
  - uniform administrative criteria for eligibility and billing,
  - single forms,
  - single open formulary;
- accountability;
- consistency in benefit coverage limitations related to scientific evidence and expert opinion;
- timeliness;
- responsiveness: correction of defects; and
- appropriate funding

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

Massachusetts Health Reform Law
The Massachusetts Medical Society (MMS) will continue its efforts in support of the implementation of the Massachusetts Health Reform Law (Chapter 58 of the Acts of 2006), working in concert with appropriate entities. *(HP)*

The MMS will inform its membership, through existing educational and communications channels, about the Massachusetts Health Reform Act (Chapter 58 of the Acts of 2006) and its impact on both physicians and their patients. *(D)*

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

Patient Protection
The Massachusetts Medical Society in its ongoing discussions on health system reform with Congress, the Administration and the American Medical Association, will continue to assign first priority to responding to the needs of the patients we serve. *(HP)*

MMS House of Delegates, 11/17/95
Reaffirmed MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16

Special Commission on the Health Payment System
That the Massachusetts Medical Society advocate that any legislation based upon recommendations of the Special Commission on the Health Care Payment System allow the existence of accountable care organizations (ACOs) as one optional methodology along with other innovative approaches to health care financing. *(D)*
MMS House of Delegates, 12/4/10

The Massachusetts Medical Society will advocate with insurers and other stakeholders to make copayments for services rendered at retail-based clinics at least equivalent to an office visit. *(D)*
MMS House of Delegates, 5/8/09
Amended MMS House of Delegates 5/7/16

Universal Access
The Massachusetts Medical Society embraces and supports (1) the assertion that health care, including preventive care, should be available to all Massachusetts residents; and (2) the facilitation of responsible actions and healthy activities and lifestyles. *(HP)*
MMS House of Delegates, 11/04/06
Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society (MMS) supports the achievement of universal insurance coverage and adopts the five principles from the Institute of Medicine's report *Insuring America's Health: Principles and Recommendations*:
i. Health care coverage should be universal.
ii. Health care coverage should be continuous.
iii. Health care coverage should be affordable to individuals and families.
iv. The health insurance strategy should be affordable and sustainable for society.
v. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable. *(HP)*
MMS House of Delegates, 5/13/05
Amended and Reaffirmed MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Item 2 of Original: Sunset)

The Massachusetts Medical Society will utilize existing research and data to explore various options for providing universal access to health care, including single-payer, and convey this information to Society members.
(D)

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

The Massachusetts Medical Society strongly asserts that the fundamental goal of any change to the American health care system should be to provide universal access to medical care for all Americans.

Any proposed change to the American health care system which will decrease the likelihood of movement towards universal access to health care for all Americans will be strongly opposed by the Massachusetts Medical Society.

Reaffirmed MMS House of Delegates, 5/14/10
(Item 3 of 3, Sunset)

HOSPITALS

Compensation/Physician Services

The Massachusetts Medical Society believes hospitals should provide mutually agreeable, negotiated compensation to physicians for the services physicians provide to hospitals. *(HP)*

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

Credentialing

The MMS will work with the Massachusetts Hospital Association to develop ways to simplify the hospital credentialing process for physicians and centralize hospital credentialing. *(D)*

MMS House of Delegates, 11/15/08, 5/8/09*
Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society (MMS) will continue to promote the use of a uniform application form for credentialing and re-credentialing to all Massachusetts hospitals, other health care facilities, managed care organizations**,** and other health care insurers**.**

MMS House of Delegates, 5/13/05
Item 1 of Original Reaffirmed MMS House of Delegates, 5/19/12
(Item 2 of Original: Sunset)

The Massachusetts Medical Society (MMS) shall work with all concerned parties to advocate for uniform minimum standards, based on available evidence, for credentialing physicians.

The MMS encourages uniformity for the process, timing, and standards for credentialing with health care institutions and managed care organizations.

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

The MMS supports the concept that credentialing of physicians by hospitals, managed care organizations, and other health care facilities be based on the evaluation of the individual's training and experience in the light of nationally accepted testable clinical care criteria.

The MMS will investigate the best methods of adherence to these criteria by health care delivery organizations in credentialing physicians to assure that all are centered on maintaining high standards of quality of care. In no case should credentialing or standards be developed or imposed for economic purposes, but only for the protection of patients.

The MMS will continue to work with state regulatory agencies to assure that any state imposed credentialing standards which limit the ability of licensed Massachusetts physicians to practice at any licensed facility are developed with evidenced based standards developed by physicians.

The MMS in its interactions with state government shall advocate for the use of the MMS's *Principles for Profiling of Physician Performance*, adopted November 1998.

In any case when new regulations establishing minimum clinical standards are proposed by state agencies, the MMS should establish a representative working group, coordinated by an established MMS Committee, to help formulate the MMS response and to advocate for adherence to the *Principles for Profiling of Physician Performance.*

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

Hospital and Health Care Facility Closings
The Massachusetts Medical Society adopts the following principles regarding Health Care Facility Closure—Physician Credentialing Records:

1. *Governing Body to Make Arrangements*
   The governing body of the hospital, ambulatory surgery facility, nursing home, or other health care facility shall be responsible for making arrangements for the disposition of physician credentialing records or CME information upon the closing of a facility. The governing body shall send notification of the impending closure to all those physicians credentialed at that facility at least 30 days prior to the date of closure.

2. *Transfer to New or Succeeding Custodian*
   Such a facility shall attempt to make arrangements with a comparable facility for the transfer and receipt of the physician credentialing records or CME information. In the alternative, the facility shall seek to make arrangements with a reputable commercial storage firm. The new or succeeding custodian shall be obligated to treat these records as confidential.

3. *Documentation of Physician Credentials*
   The governing body shall make appropriate arrangements so that each physician will have the opportunity to make a timely request to obtain a copy of the verification of his/her credentials, clinical privileges, CME information, and medical staff status.

4. *Maintenance and Retention*
   Physician credentialing information and CME information transferred from a closed facility to another hospital, other entity, or commercial storage firm shall be maintained in a secure manner intended to protect the confidentiality of the records. The records shall be maintained for a period of at least two years from the date the facility closes.

5. *Access and Fees*
   The new custodian of the records shall provide timely access at a reasonable cost and in a reasonable manner that maintains the confidential status of the records. *(HP)*

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

The MMS will work with appropriate state bodies to assure that whenever there is either a threatened or an actual hospital closure, a process be instituted to safeguard the continuity of patient care and preserve the physician-patient relationship; this process should also assure that adequate capacity exists or can be developed in the immediate area surrounding the hospital closure to provide for the citizens of that area, and that whenever there is a threatened or actual hospital closure, restrictive covenants and financial barriers, which prevent the movement of physicians and their patients to surrounding hospitals, should be re-examined and waived for an appropriate period, so continuity of care is preserved. *(D)*

The MMS will work with appropriate interested parties to study new models of oversight and health care planning that include such items as: (A) Mandatory concurrent, ongoing financial reporting by health care organizations to an appropriate oversight entity to facilitate early identification of any hospital in financial distress; (B) A process to intervene when such financial instability is detected; and (C) A process to assure adequate funding to maintain the health care delivery system and to insure access to health care for the citizens of Massachusetts. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Items 1-3 and 5-6 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16

Hospitalists
The Massachusetts Medical Society endorses the following principles developed by the American Medical Association, American Hospital Association, the Joint Commission, the Centers for Medicare and Medicaid Services, and the Society of Hospital Medicine:

Principles for a Sustainable and Successful Hospitalist Program

Vision

1. Seek to involve and address the needs of all key stakeholders in designing and implementing a hospitalist program. These stakeholders include patients, the medical staff, other clinical professionals, hospital administration, and the hospitalists.
    - Patients: A hospitalist program introduces a new "player" into the healthcare system. Patients expect to have their primary care physician (PCP) treating them when they are admitted to the hospital. As such, it is important that all parties (the PCP, the hospital, and the hospitalist) develop communication programs that explain the hospitalist model. Brochures and newsletters are tools that can be used to improve communications. Also, it is important to measure patient satisfaction. When evaluating patient satisfaction with hospitalists, recognize that there are factors that can negatively impact these ratings — specifically, the likelihood that the patients have been admitted through the emergency department and they are expecting care from their PCPs.
    - Medical Staff: Hospitalist programs can provide a significant service to other physicians at the hospital. Specifically, 1) PCPs may not want to do emergency call at the hospital; 2) PCPs may decide that doing inpatient care is not cost effective and/or it disrupts their office-based practice; 3) surgeons and specialists may seek hospitalist support in handling more routine inpatient care and/or in co-managing their patients; and 4) emergency physicians and hospitalists have to work together to treat and admit patients. As such, it can be helpful to involve the medical staff in the design, implementation, and review of the hospitalist program. A "Hospitalist Advisory Committee" may be a useful vehicle for addressing these issues. A hospitalist program may want to implement satisfaction surveys, to determine how the hospitalists are perceived by other members of the medical staff. Also, hospitalists should be involved in medical staff activities and in its leadership.
    - Other Clinical Professionals: The care and treatment of medical inpatients requires coordination among all of the clinical professionals in the hospital — nurses, case managers, social workers, physical therapists, etc. These professionals also can play a role in the development and implementation of a hospitalist program. If nurse turnover is an issue at the hospital, hospitalists may play a role in addressing nurse satisfaction.
    - Hospital Administration: Hospital administrators often define the goals and provide the financial support for hospitalist programs. By definition, they will play a key role in designing and monitoring the hospitalist program.
    - Hospitalists: Hospitalists need to be treated as professional colleagues and as equal, legitimate members of the medical staff, not as contractors hired to do the work that other physicians do not want to do. A successful hospitalist program will acknowledge the importance of physician satisfaction and the risks and dangers to the program of the potential burnout of hospitalists.

NOTE: In developing and implementing the goals of the hospitalist program, a balance must be sought among the interests of the various stakeholders. Issues may arise if it appears that the interests of one group of stakeholders (i.e., the hospital administrators, the medical staff, other clinical staff, the hospitalists) is overemphasized.

2. Promote a hospitalist model that focuses on team-based inpatient care. The delivery of inpatient medical care often suffers from coordination problems. During the hospital stay, patients and their family members may have to sort through information, diagnoses, and treatments from an attending physician, consulting specialists, nurses, residents, therapists, social workers, case managers and others. Effective inpatient care is a "team sport." Since hospitalists spend virtually all of their time in the hospital, there is a unique opportunity for hospitalists and other clinical professionals to develop shared goals, mutual respect, and improved communication. A team-based model of inpatient care can result in superior coordination of care and patient outcomes.

3. Recognize the potential of hospitalists to help address vital strategic issues for the hospital. These concerns include financial pressures; staffing shortages and dissatisfaction; quality and patient safety; new technologies; employer and consumer demands for performance metrics; capacity constraints; and increased competition. Many physicians are no longer able or willing to serve on hospital committees or play a leadership role for the medical staff. Hospitalists have the potential to step in and help address these key issues for the following reasons:
    - Hospitalists spend the majority of their time in the inpatient environment, making them familiar with hospital systems, policies, services, departments, and staff.

- Hospitalists are inpatient experts who possess clinical credibility when addressing key issues regarding the inpatient environment.
- Many hospitalists are hospital employees who can understand the tradeoffs involved in balancing the needs of the institution with those of the medical staff, the referral sources, and the patients. Even hospitalists who are not employed by the hospital have an intimate knowledge of the issues that the hospital is facing and are invested in finding solutions to these problems.

4. Anticipate the ongoing evolution in the scope of hospitalist practice. As hospitalist programs mature within their organizations, often the hospital leadership and medical staff seek to expand the role and responsibilities of hospitalists. All hospitalists should be prepared for an evolving set of responsibilities that may expand beyond the traditional scope of their training background. If hospitalists agree to assume broader responsibilities, they may need to acquire additional skills and expertise. That being said, the hospital leadership and medical staff should be careful not to overburden the hospitalists or mandate new responsibilities for the hospitalists. A balance must be sought that addresses a reasonable workload, the skills of the hospitalists, and the needs of the institution.

Organization/Structure

5. Choose a hospitalist leader with the right skills and experience. Selecting the right leader is fundamental to a successful hospitalist practice. These individuals are hard to find. They must be excellent clinically and have superb communications skills. Although they need to be assertive, they must also be good listeners. Political skills are essential to navigate medical staff, departmental, and administrative issues. An understanding of and appreciation for practice economics will help to ensure that revenue is optimized and benefits to the financial supporters of the program are tracked.

6. Build structure and incentives with the goal of creating an "ownership" mentality for hospitalists in the practice. Hospitalists need to think of themselves as owners of their practice, even if they are employees or contractors of a hospital or multispecialty clinic. An employee or "shift" mentality may lead to hospitalists unwilling to step in to help out other physicians (both hospitalists and non-hospitalists) or to stay until the work is done. They may feel like it is someone else's problem to address the financial status of the hospitalist program. There are many ways that a hospitalist program can create this sense of ownership, but perhaps the most effective is to implement a compensation system that rewards performance, including productivity and clinical quality. The goal of the compensation model and incentives should be to connect physician incomes with the economic health and/or clinical quality of the practice. Ongoing training and education with regular audits for proper documentation, billing, and coding are essential to maximizing reimbursement for the work that has been done and to maintaining fiscal viability of any program. Physicians who are in a hospital employee or "guaranteed salary" practice model may be particularly vulnerable to neglecting proper billing and coding since this might not affect their individual income, but this has tremendous impact on the financial health of both the program and the hospital.

7. Assure that the hospitalist practice has the necessary tools and support to achieve their objectives: Like any physician practice, a hospitalist program needs adequate administrative support to help with billing, performance reporting, tracking patient census and volumes, information exchange with PCPs, etc. The practice may want to consider purchasing one of the hospitalist software products available in the marketplace. Also, hospital administration should assure that the hospitalists have access to other hospital departments such as information systems, finance, and utilization reporting. Finally, the medical director of the hospitalist program needs sufficient non-clinical time to address administrative and leadership issues.

Relationships/Communications

8. Use of hospitalist program should be optional for referring physicians and should never be mandated, especially not by hospital administration or by third party payers. Success of a hospitalist program requires the support and "buy-in" of all of the stakeholders involved in its use, particularly the referring physicians and the patients. Under no circumstances should a PCP be required to refer patients to a hospitalist program in lieu of caring for that patient him/herself. Likewise, no third-party payors should require patients be followed by a hospitalist rather than their PCPs they have chosen, unless the PCP is not contracted with the payor or the facility. PCPs may choose to forgo rounding on their own hospitalized patients and this, in turn, may require those patients to see a different physician, but those patients could usually then choose a different physician that still makes rounds if this is their preference.

9. Develop a process for identifying, addressing, and resolving issues between hospitalists and the medical staff. Whenever a hospitalist program is introduced at a hospital, a range of new "practice" issues arise with the medical staff. Examples include: 1) the roles of the hospitalist and the emergency physician; 2) the role of the hospitalist in providing emergency department call; 3) the responsibilities of the hospitalist and the surgeon when co-managing

a patient; 4) the responsibilities of the hospitalist and the medical specialist when co-managing a patient; 5) the availability of specialists for consultations; 6) the hospitalist's choice of consultants; and 7) the timeliness of hospitalist communications to PCPs; etc. Physician leadership at the hospital (e.g., a Chief Medical Officer or Vice President – Medical Affairs) can play a vital role in identifying and resolving these issues. Some hospitals have used a "Hospitalist Advisory Committee" to address the issues.

10. Assure hospitalists and community physicians share accountability for the patient and the exchange of patient information in a timely manner. Community physicians (typically PCPs) refer their patients to hospitalists for inpatient care. This creates a discontinuity of care and both parties must assume a level of accountability. At admission, the PCP must be sure that the hospitalist receives all information need to treat the patient. At discharge, the hospitalist must dictate discharge notes which should be transcribed and transmitted to the referring doctor on a "stat" basis. It is at these "transitions of care" that there are risks to the patient. Both parties must be diligent to assure that key information (medications, test results, follow up requirements, etc.) is transmitted and acted upon in a clear and timely fashion. During the hospitalization, the hospitalist needs to communicate to the PCP if there are significant changes in the patient's condition; the PCP should be accessible if any new issues arise that may require further input or information.

11. Establish regular communication and dialog between the hospital leadership and the hospitalist program. Hospital leadership needs to review the performance of the hospitalist program to assure that the objectives are being met. The hospitalists need access to hospital administrators and medical staff leaders to address obstacles or barriers to their performance. In successful hospitalist programs, there are periodic meetings between the two parties at which these topics are discussed and action plans are developed for moving forward.

Operations/Management

12. Design a flexible schedule for the hospitalists that recognizes competing priorities and demands. A hospitalist's schedule should take into account the following variables:
    - Patient-hospitalist continuity over the course of the hospital stay. Ideally, a patient should see the same hospitalist throughout his or her hospital stay. This is likely to improve patient satisfaction, reduce errors, and increase hospitalist efficiency.
    - The bimodal distribution in work over the course of the day. A typical day for a hospitalist practice follows this pattern: 1) it is very busy with rounds on existing patients from early in the morning until sometime in the early afternoon; 2) then it is relatively quiet in the early afternoon; 3) finally it gets busy again with admissions from late afternoon until about 10 p.m. to midnight.
    - Sustainable physician lifestyle. Is the group's schedule one that a doctor could work for many years? Or do problems arise such as regular night work leading to sleep deprivation or working too few days annually so that each worked day requires a very high patient load? Does the schedule protect extended "block time off" but trade this for working too many days consecutively so that physicians are exhausted by the end of the "long stretch?"
    - Reasonable provision for night work. Once a hospitalist group is admitting six to eight patients per day, the program should consider a separate night shift staffed by a doctor who has no daytime responsibility the day before or after. Ideally, the practice should have one or more dedicated "nocturnists" who work only at night, while the remaining doctors in the group work only during the daytime.
    - Adaptability and scalability. Every group should think about how their schedule might change if/when patient volume grows and one or more doctors are added. Growth will often require changing the schedule significantly, rather than just adding new doctors into the existing scheduling rotation.

13. Staff the hospitalist program in a way that recognizes the potential for growth, the daily variations in patient volume, and the hospitalists' responsibilities: A significant problem encountered by many hospitalist programs is patient volume growth that occurs more quickly than anticipated. Recruiting lead times for hospitalists are long and physician turnover is common. A frequent cause of hospitalist practice crisis or failure is an overwhelmed hospitalist team. A hospitalist program should staff in a way that appropriately anticipates growth in patient volume.

    From day-to-day, there are significant variations in the volume of patients demanding care from hospitalists. Hospitalist staffing needs to recognize this variation. A cap on patient volume for individual hospitalists in the practice can be a useful tactic. Specifically, when one doctor reaches the cap in patients, other hospitalists help out. Finally, as previously described, hospitalists often have broad non-patient care responsibilities within the hospital — leading projects, staffing committees, etc. The hospitalist staffing model must provide sufficient "protected time" for these activities.

14. Track and report hospitalist performance measures against goals: In conjunction with the hospital and the medical staff, the hospitalist practice should establish performance goals and metrics. By tracking performance against these measures, variations can be picked up earlier in the process and corrective actions introduced. The program should generate periodic performance reports on parameters such as clinical quality, resource utilization, practice economics, physician productivity, and satisfaction (of patients, referring physicians, nurses, and hospitalists). These performance reports should be shared with the hospitalists in the practice and other stakeholders (e.g. hospital quality program) as appropriate.

15. Focus on effective revenue cycle management for the hospitalist program through systems, training, and reporting. Unless patient encounters are coded properly, billed accurately and promptly, and collected fully, the hospitalist practice will experience significant deficits and/or require excessive levels of subsidization. Hospital billing departments may not be familiar with the role of hospitalists. In those situations, seek out a vendor that has experience in the hospitalist field and check its references. Make sure it has integrated a compliance program into the coding and billing process and has the ability to provide complete activity and trend reports.

    Poor coding, especially under-coding, is a common problem among hospitalist programs. This is especially true for programs that have not implemented production based incentives. Educating the doctors in coding and undertaking regular audits of their performance is worth the effort and expense. It can lead to significant additional revenue to the hospitalist practice, potentially reducing the amount of financial support required from the hospital or medical group.

(HP)

MMS House of Delegates, 5/14/10

Hospital Admissions

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

The Massachusetts Medical Society advocates that hospital admission processes should include the following:

a. A determination of whether the patient has an existing relationship with an actively treating primary care or specialty physician;
b. Prompt notification of such actively treating physician(s) where such a relationship exists;
c. Notice to the patient that he/she may request and receive treatment or consultation by such actively treating physician(s) if the physician has the relevant clinical privileges at the hospital;
d. Honoring patient requests that the physician of their choice treat them or consult on their care; and
e. Allowing actively treating physicians to treat to the full extent of their hospital privileges.

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

The MMS will continue to work with the American Medical Association (AMA) to monitor utilization management policy to ensure that hospital admissions are reviewed by appropriately qualified physicians. *(D)*

The MMS will seek legislation requiring that hospital-admission utilization review for insurers be conducted by physicians licensed in Massachusetts, and also require utilization review organizations to have appropriately staffed offices and be registered with state health regulatory agencies where they are providing services. *(D)*

The MMS will maintain that the determination of the medical necessity for hospital admission should be made only by a doctor of medicine or a doctor of osteopathy licensed in the same jurisdiction as the treating physician. *(HP)*

The MMS will recommend that the AMA work with the Centers for Medicare and Medicaid Services and other stakeholders to address reclassifications of hospital admissions and make sure a process is in place prohibiting software screening programs from substituting for physicians' medical judgement. *(D)*

The MMS supports principles for preadmission reviews of hospital admissions, including that such reviews should be performed by physicians or under close supervision of physicians; adverse decisions concerning hospital admissions should be finalized only by physician reviewers; and preadmission review programs should provide for immediate hospitalization of any patient whose treating physician determines the admission is an emergency. *(HP)*
MMS House of Delegates, 5/2/15

Hospital/Organized Medical Staff/Employed Physicians
All medical staff bylaws should include multiple methods (such as online voting, and other secure methods) for insuring that all the medical staff members are made fully aware of the timing and importance of elections and agenda items that require a vote. *(HP)*

All medical staff bylaws recommend that each medical staff create a methodology based on a representative quorum of each of the designated groups in order to provide voice and vote to those who are eligible, and that such votes be tallied separately to insure proportionate representation from each group. *(HP)*

All medical staff bylaws should specify that there must be participation in elections of an agreed-upon percentage of each category of eligible voting physicians, and other categories such as employed and contracted physicians, and those who are hospital based and non-hospital based, to be determined by the medical staff. *(HP)*

At least one non-hospital-based physician should be represented on the medical executive committee, and stipulated in the medical staff bylaws. *(HP)*

The composition of the medical executive committee should reflect the percentages of the various voting categories. *(HP)*

MMS House of Delegates, 12/5/15

The MMS will support and revise its model medical staff bylaws as appropriate to reflect the following guidelines regarding the qualifications and selection of individuals employed by or under contract with a hospital/health system to provide medical management services, such as medical directors, chief medical officers, and vice presidents for medical affairs:

a. The hospital governing body, management, and medical staff should jointly: (i) determine if there is a need to employ or contract with one or more individuals to provide medical management services; (ii) establish the purpose, duties, and responsibilities of these positions; (iii) establish the qualifications for these positions; and (iv) establish and sustain a mechanism for input from and participation by elected leaders of the medical staff in the selection, evaluation, and termination of individuals holding these positions.
b. An individual employed by or under contract with a hospital or health system to provide medical management services should be a physician (MD/DO).
c. A physician providing medical management services at a single hospital should be licensed to practice medicine in the same state as the hospital for which he or she provides such services. Additionally, he or she should be a member in good standing of the organized medical staff of the hospital for which he or she provides medical management services.
d. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be licensed to practice medicine in each of the states in which the health system has a hospital that will be influenced by the physician's work. At a minimum, the physician should be licensed in at least one state in which the health system has a hospital over which the physician will exert influence, and in as many other states as may be required by state licensing law.
e. Where feasible, a physician providing medical management services at the system level for a multi-hospital health system should be a member in good standing of the medical staff of each of the hospitals that will be influenced by the physician's work. At a minimum, the physician should: (i) be a member in good standing of at least one of the medical staffs of the hospitals that will be influenced by the physician's work; and (ii) work in collaboration with elected medical staff leaders throughout the system and with any individuals who provide medical management services at the hospital level.

(D)

2.That the MMS support and revise its model medical staff bylaws as appropriate to reflect the following guidelines regarding the role of the organized medical staff vis-à-vis individuals employed by or under contract with hospitals/health systems to provide medical management services:

a. The purpose, duties, and responsibilities of individuals employed by or under contract with the hospital/health system to provide medical management services should be included in the medical staff bylaws and in the hospital/health system corporate bylaws.

b. The organized medical staff should maintain overall responsibility for the quality of care provided to patients by the hospital, including the quality of the professional services provided by individuals with clinical privileges, and should have the responsibility of reporting to the governing body.

c. The chief elected officer of the medical staff should represent the medical staff to the administration, governing body, and external agencies.

d. Government regulations that would mandate that any individual not elected or appointed by the medical staff would have authority over the medical staff should be opposed.

(D)

MMS House of Delegates, 12/6/14

That given the limited utility of medical staff-hospital compacts relative to their significant potential unintended consequences, the MMS recommends that organized medical staffs and physicians not enter into compacts or similar agreements with their hospitals' governing bodies or administrations. Instead, the MMS encourages organized medical staffs and hospital governing bodies to:

1. Clearly define within the medical staff bylaws the obligations of each party;
2. Outline within the medical staff bylaws the processes by which conflicts between the organized medical staff and the hospital governing body are to be resolved; and
3. Regard the medical staff bylaws as a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body.

(HP)

MMS House of Delegates, 12/7/13

The Massachusetts Medical Society adopts the following Principles for Physician Employment:

Principles for Physician Employment

1. Addressing Conflicts of Interest

(a) A physician's paramount responsibility is to his or her patients. Additionally, an employed physician is likely to feel some sense of obligation to his or her employer. This divided loyalty can create conflicts of interest, such as financial incentives to over- or under-treat patients, which employed physicians should strive to recognize and address.

(b) Employed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

(c) In any situation where the economic or other interests of the employer are in conflict with patient welfare, patient welfare must take priority.

(d) Physicians should always make treatment and referral decisions based on the best interests of their patients. Employers and the physicians they employ must assure that agreements or understandings (explicit or implicit) restricting, discouraging, or encouraging particular treatment or referral options are disclosed to patients.

(e) Taking a title or position that removes a physician from direct patient care does not override professional ethical obligations. Physicians whose administrative actions or business decisions override the individual patient care decisions of other physicians are engaged in the practice of medicine and subject to professional ethical obligations, and may be held legally responsible for such decisions.

(f) Physicians who hold administrative leadership positions should use whatever administrative and governance mechanisms that exist within the organization to foster policies that enhance the quality of patient care and the patient care experience.

2. Advocacy for Patients and the Profession

(a) Patient advocacy is a fundamental element of the patient-physician relationship that should not be altered by the health care system or setting in which physicians practice.

(b) Advocacy for the profession is also a fundamental element of the delivery of quality care and it too, should not be altered by the health care system or the methods by which physicians are compensated.

(c) Employed physicians should be free to engage in volunteer work outside of, and which does not interfere with, their duties as employees.

3. Contracting

(a) Physicians should be free to enter into mutually satisfactory contractual arrangements, including employment, with hospitals, health care systems, medical groups, insurance plans, and other entities as permitted by law and in accordance with the ethical principles of the medical profession.

(b) Physicians should never be coerced into employment with hospitals, health care systems, medical groups, insurance plans, or any other entities. Employment agreements between physicians and their employers should be negotiated in good faith. Both parties should obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts.

(c) When a physician's compensation is related to the revenue he or she generates, or similar factors, the employer should make clear to the physician the factors upon which compensation is based.

(d) Termination of an employment or contractual relationship between a physician and its employer does not necessarily end the patient-physician relationship between the employed physician and persons under his or her care. When a physician's employment status is unilaterally terminated by an employer, the physician and his or her employer should notify the physician's patients that the physician will no longer be working with the employer and should provide them with the physician's new contact information. Patients should be given the choice to continue to be seen by the physician in his or her new practice setting or to be treated by another physician still working with the employer. Records for the physician's patients should be retained for as long as they are necessary for the care of the patients or for addressing legal issues faced by the physician; records should not be destroyed without notice to the former employee as stated in the physician employment contract and as governed by law.

(e) Physician employment agreements should contain provisions to protect a physician's right to due process before termination for cause. Physician employment agreements should specify whether or not termination of employment is grounds for automatic termination of hospital medical staff membership or clinical privileges.

(f) Physician employment agreements should contain dispute resolution provisions. If the parties desire an alternative to going to court, such as arbitration, the contract should specify the manner in which disputes will be resolved.

4. Hospital Medical Staff Relations

(a) Employed physicians should be members of the organized medical staffs of the hospitals or health systems with which they have contractual or financial arrangements, should be subject to the bylaws of those medical staffs, and should conduct their professional activities according to the bylaws, standards, rules, and regulations and policies adopted by those medical staffs.

(b) Regardless of the employment status of its individual members, the organized medical staff remains responsible for the provision of quality care and must work collectively to improve patient care and outcomes.

(c) Employed physicians who are members of the organized medical staff should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding medical staff matters and should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests.

(d) Employers should seek the input of the medical staff prior to the initiation, renewal, or termination of exclusive employment contracts.

5. Peer Review and Performance Evaluations

(a) When entering into an employment contract physicians should accept, and be subject to, an effective program of peer review to monitor and evaluate the quality, appropriateness, medical necessity, and efficiency of the patient care services provided within their practice settings.

(b) Peer review should follow established procedures that are identical for all physicians practicing within a given health care organization, regardless of their employment status.

(c) Peer review of employed physicians should be conducted independently of, and without interference from, any human resources activities of the employer. Physicians - not lay administrators - should be ultimately responsible for all peer review of medical services provided by employed physicians.

(d) Employed physicians should be accorded due process protections, including a fair and objective hearing, in all peer review proceedings. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right to a hearing, the opportunity to be present and to rebut evidence, and the opportunity to present a defense. Due process protections should extend to any disciplinary action sought by the employer that relates to the employed physician's independent exercise of medical judgment.

(e) Employers should provide employed physicians with regular performance evaluations, which should be presented in writing and accompanied by an oral discussion with the employed physician. Physicians should be informed before the beginning of the evaluation period of the general criteria to be considered in their performance evaluations, for example: quality of medical services provided, nature and frequency of patient complaints, employee productivity, employee contribution to the administrative/operational activities of the employer, etc.

(f) Unless specified otherwise in the employment agreement, upon termination of employment with or without cause, an employed physician should not be required to resign his or her hospital medical staff membership or any of the clinical privileges held during the term of employment, unless an independent action of the medical staff calls for such action, and the physician has been afforded full due process under the medical staff bylaws.

6. Payment Agreements

(a) Although they typically assign their billing privileges to their employers, employed physicians or their chosen representatives should be prospectively involved if the employer negotiates agreements for them for professional fees, capitation or global billing, or shared savings. Additionally, employed physicians should be informed about the actual payment amount allocated to the professional fee component of the total payment received by the contractual arrangement.

(b) Employed physicians should retain the right to review billing claims as may be necessary to verify that such bills are correct. Employers should indemnify and defend, and save harmless, employed physicians with respect to any violation of law or regulation or breach of contract in connection with the employer's billing for physician services, which violation is not the fault of the employee.

7. Physician Independence and Self-Governance

(a) The MMS will (1) continue to assess the needs of employed physicians, ensuring autonomy in clinical decision-making and self-governance; and (2) promote physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including but not limited to hospitals, health care systems, medical groups, insurance company networks, and accountable care organizations, in order to assure and be accountable for the delivery of quality health care.
(b) That the MMS will disseminate the Principles for Physician Employment to graduating residents and fellows and will advocate for adoption of these Principles by organizations of physician employers such as, but not limited to, the Massachusetts Hospital Association and the Massachusetts Medical Group Management Association.
(HP)

The MMS:
(1) adopts as policy the principle that a medical staff member's financial relationships, including employment or contractual relationships, or lack thereof, with a hospital or health care delivery system should not determine the physician's eligibility for: election or appointment to medical staff leadership positions; voting on medical staff matters; or otherwise participating in the self-governance activities of the medical staff.

(2) will continue to update and encourage medical staffs to adopt model medical staff bylaws provisions supporting the principle that a medical staff member's financial relationships including employment or contractual relationships, or lack thereof, with a hospital or health care delivery system should not determine the physician's eligibility for: election or appointment to medical staff leadership positions; voting on medical staff matters; or otherwise participating in the self-governance activities of the medical staff and encourage medical staffs to adopt and incorporate into their bylaws conflict-of-interest policies that reflect the following principles:

(a.) Full disclosure of conflicts.

– Nominees for election or appointment to medical staff offices, department or committee chairs, including all members of the nominating committee, or the medical executive committee should fully disclose in writing to the medical staff, prior to the date of election or appointment, any

- personal,
- professional,
- or financial affiliations or relationships of which they are reasonably aware – including employment or contractual relationships, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

– Elected or appointed medical staff leaders should fully disclose such Conflicts of interest in writing to the medical staff whenever they arise.

(b.) Management of conflicts. Once fully disclosed, when conflicts of interest exist:

– Elected or appointed medical staff leaders should, as appropriate, voluntarily abstain from voting on the matter to which the conflict relates, or recuse themselves from the decision-making process and participation in the matter to which the conflict relates.

– The medical staff should establish a process for involuntarily recusal of any elected or appointed medical staff leader who fails to fully disclose a potential conflict of interest, to abstain from voting, or to recuse himself or herself from the decision-making process and participation in the matter to which the conflict relates.
(D)/(HP)

MMS House of Delegates, 5/11/13

The Massachusetts Medical Society should become the lead association for physicians in Massachusetts who maintain employment or contractual relationships with hospitals, health systems, and other entities. *(D)*

The MMS will work through the Organized Medical Staff Section, other sections and special groups, or a newly created section (similar to the AMA's Integrated Physician Practice Section) as appropriate to represent and address the unique needs of employed physicians in hospitals, health systems, and other entities. *(D)*

That as a benefit of membership, the MMS should provide assistance through existing resources and the Organized Medical Staff Section, such as information and advice (but not legal opinions or representation) as appropriate to residents and fellows, employed physicians, physicians in independent practice, and independent physician contractors. Such information and advice should address matters pertaining to their relationships with hospitals, health systems, and other entities, including, but not limited to, breach of contracts, medical staff bylaws, sham peer review, economic credentialing, and the denial of due process. *(D)*

MMS House of Delegates, 5/19/12

The Massachusetts Medical Society will establish policy stating that an existing medical staff should have the right to reorganize and redefine its own governance structure as appropriate. *(HP)*

The MMS will advocate for all properly licensed and hospital credentialed physicians involved in patient care to be eligible for voice and vote in organized medical staff self-governance. *(D)*
The MMS establishes policy that affirms that the medical staff, as a principle of self-governance, should be a representative democracy where the members personally participate with voice and vote in the decision-making and election of their representatives. *(HP)*

MMS House of Delegates, 5/14/10

The Massachusetts Medical Society (MMS) supports a minimum set of self-governance attributes of the hospital medical staff, the essence of which will lead to improved patient care and better relationships between hospitals and their physicians, and would include:

- The initiation, development, adoption, and amendment of medical staff bylaws, rules, and regulations, subject to approval of the hospital governing body, from which approval shall not be unreasonably withheld
- The establishment and enforcement of criteria and standards for medical staff membership and privileges consistent with applicable laws and regulations, as well as with MMS policy and American Medical Association and the Joint Commission

- The establishment and enforcement of clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities such as periodic meetings of the medical staff and its committees and review and analysis of patient medical records
- The selection and removal of medical staff officers
- The establishment and collection of medical staff dues and use of the dues fund consistent with the purposes of the medical staff
- The right of the medical staff as an entity to access and use independent legal counsel at the expense of the medical staff
- The right of the medical staff to seek an injunction in court to protect its self-governance authority from interference by the hospital governing body or administration

(D)

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

The Massachusetts Medical Society will continue to work to bring about a better understanding in collaboration between hospitals and physicians.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Amended and Reaffirmed MMS House of Delegates, 5/14/10

Mergers or Conversions
Statement of Principles for Conversions and Mergers

A. Community Health Impact:

(1) Any proposed merger or conversion should assure access to high quality patient care and medically necessary services appropriate to the community's needs.

(2) The proposed new entity should be obligated to provide the same or enhanced levels of services in the following areas:

- care to the uninsured and other vulnerable populations
- community health
- education and teaching
- research

(3) The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger and should be committed to for a defined period. Procedures should be established for effective independent monitoring of those services to assure compliance with the agreed upon commitments and assessment of their effect on the community health status.

(4) Public hearings should be held to assure full public discussion of the proposed new entity and community concerns should be given full hearing. The proposed new entity should develop a written plan which addresses those community concerns before final approval of the proposed conversion or merger.

B. Oversight Requirements

(1) There should be full compliance with all requirements set forth by the Office of the Massachusetts Attorney General and the Massachusetts Department of Public Health.

(2) An independent appraisal of assets should be completed prior to a for-profit conversion.

(3) Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited.

(4) All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed.

(5) The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation.

(6) The level of compensation for officers, trustees, directors and employees of the newly formed entity and the charitable foundation, when applicable, should be at an appropriate market rate.

Implementation Strategies

(1) Issue: Staffing Levels – With respect to Principle A.1.: "Any proposed merger or conversion should assure access to high quality patient care . . .." One key determinant of the quality of patient care is the adequacy of medical staffing. Strategy: After the conversion or merger, staffing levels should be appropriate to provide high quality patient care.

(2) Issue: Service Changes – With respect to Principle A.3.: "The health services to be provided by the new entity should be defined prior to the approval of the conversion or merger . . ." Appropriate information needs to be made available to the community in a timely manner, so as to enable the community to provide effective input to the process. Strategy: The new entity should identify both current services and those services it proposes to provide. As further modifications of services are proposed, the community should be informed and their input sought.

(3) Issue: Monitoring – With respect to Principle A.3.: "Procedures should be established for effective independent monitoring . . .." Because the affected community has the most at stake, it should be given the mandate and resources needed to perform this task. Strategy: Effective monitoring may be achieved by a local advisory board with significant autonomy.

(4) Issue: Private Inurement – With respect to Principle B.3.: "Private inurement to officers, trustees, directors and employees of the converting or merging entities should be prohibited." Decisions regarding conversions and mergers should be made solely on the basis of the best interests of the converting or merging entity and the community it serves. Strategy: Such abuses of trust should be aggressively investigated and prohibited by law or regulation, with penalties for violations.

(5) Issue: Conflicts of Interest – With respect to Principle B.4.: "All actual and potential conflicts of interest by officers, trustees, directors and employees of the converting or merging entities should be publicly disclosed." The purpose of this recommendation is to inform the community about the possible motives of key decision-makers in the conversion or merger process. Strategy: All disclosures of conflicts of interest should be documented in writing.

(6) Issue: Charitable Foundations – With respect to Principle B.5.: "The mission of any charitable foundation that is established after a conversion should be limited to improving the health of the community. Such foundations should be governed by a local board of directors with meaningful community and physician participation." And, Principle B.6., states: "The level of compensation for officers, trustees, directors and employees of . . . the charitable foundation . . . should be at an appropriate market rate." Charitable foundations formed with the assets of a converting entity have great potential for being misused. Strategy: The mission, governance, operations and management of such foundations should be subject to public scrutiny and focused on health care.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Neonatal Outcomes and Care

The Massachusetts Medical Society (MMS) will continue to oppose defining levels of neonatal care based on the volume of deliveries at a hospital. *(D)*

The MMS will continue to work with the Massachusetts Department of Public Health and with the Massachusetts Hospital Association to ensure continued quality surveillance of neonatal outcomes. *(D)*

MMS House of Delegates, 12/3/05
Reaffirmed MMS House of Delegates, 5/19/12

Network Adequacy
That the MMS adopt the following adapted from American Medical Association policies to address the issue of network adequacy for patient access:

> The MMS supports the Massachusetts Legislature, the Division of Insurance, and other appropriate state regulators as the primary enforcer of network adequacy requirements for patient access. *(HP)*
>
> The MMS supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. *(HP)*
>
> The MMS supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy as evaluated by patient access measures, including geographic location, the number and type of providers that have joined or left the network, the number and type of specialists and subspecialists that have joined or left the network, the number and types of providers who have filed an in-network claim within the calendar year; the total number of claims by provider type made on an out-of-network basis; data that indicates the provision of Essential Health Benefits; and consumer complaints received. *(HP)*
>
> The MMS supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. *(HP)*
>
> The MMS supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. *(HP)*
>
> The MMS supports state legislative and regulatory efforts to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. *(HP)*
>
> The MMS supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. *(HP)*
>
> The MMS will advocate for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies. *(D)*
>
> The MMS will advocate for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited. *(D)*
>
> The MMS will advocate that health plans should be required to document and report to regulators that they have met requisite standards of network adequacy for hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists, and hospitalists) at in-network facilities. *(D)*

MMS House of Delegates, 5/7/16

Patient and Family Advisory Councils
The MMS supports the inclusion of feedback from Patient and Family Advisory Councils in guiding hospitals as they deliver quality health care. *(HP)*

MMS House of Delegates, 12/3/16

Personal and Financial Information
That because inappropriate disclosures and use of physicians' personal and financial information may not be prohibited by law, the Massachusetts Medical Society (MMS) will take prompt action to inform hospital medical staff members about the risks involved in disclosing personal and financial information (including proprietary business, ownership, strategic, and income information) until hospital administrators have taken steps to protect that information from misuse and wrongful disclosure. Such measures must include adoption of strictly enforced policies approved by the medical staff that specifically govern the maintenance, disclosure, use, and destruction of medical staff members' personal and financial information. *(D)*

The MMS will inform hospital medical staff members about the risks involved in disclosing personal and financial information (including proprietary business, ownership, strategic, and income information) to comply with hospital conflict of interest policies, because such policies may serve as a pretext to identify physician "competitors," and because such information is irrelevant to granting and exercising practice privileges. *(D)*

The MMS will inform hospital medical staff leaders about the risks involved in broad disclosures of personal and financial information (including proprietary business, ownership, strategic, and income information) pursuant to hospital conflict of interest policies for medical staff leaders, as such information is not relevant to medical staff leadership responsibilities (which are to oversee and improve patient care in hospitals), noting, however, that such disclosures may be required of hospital medical staff leaders who also serve on the board of directors of a hospital, as these individuals rightfully can be subject to a conflict of interest policy in furtherance of their duties. *(D)*
The MMS will provide information to medical staffs about steps they should take to protect members' personal and financial information (including proprietary business, ownership, strategic, and income information) that otherwise is not protected from dissemination and use. *(D)*

The MMS will initiate legislative efforts to safeguard the confidentiality of hospital medical staff members' personal and financial information (including proprietary business, ownership, strategic, and income information) disclosed pursuant to hospital conflict of interest policies. *(D)*

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

Primary Care Physicians
The MMS will study the problems associated with maintaining an organized medical staff at hospitals, and recommend an appropriate course of action and strategies that could be incorporated by locally governed medical staffs with the goal of reintroducing and reincorporating primary care physicians and others in their respective hospital-centric communities, with a report back to the HOD at I-13. *(D)*

MMS House of Delegates, 12/1/12

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

The Massachusetts Medical Society support the use of temporary privileges in the following situations:
a. To fulfill an important patient care, treatment, or service need, or
b. When an applicant for new privileges with a "clean" application is awaiting review and approval by the medical staff executive committee and the governing body. *(HP)*

The Massachusetts Medical Society will work with the American Medical Association and other stakeholders to preserve the use of temporary privileges in the following situations:
a. To fulfill an important patient care, treatment, or service need, or
c. When an applicant for new privileges with a "clean" application is awaiting review and approval by the medical staff executive committee and the governing body. *(HP)*

MMS House of Delegates, 5/7/16

Uniform Application
The Massachusetts Medical Society will work arduously and expeditiously to seek agreement with hospitals and the major managed care networks on the use of a single uniform credentialing form.

The Massachusetts Medical Society will attempt to create some logical system, with the managed care plans, to create a system whereby the providers would receive their recredentialing applications according to a uniform schedule.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Uniform Standards for Non-Profits and For-Profits
The Massachusetts Medical Society supports the concept that all for-profit hospitals or health care delivery systems be held to the same standards as not-for-profit hospitals or health care delivery systems in providing free care, support for medical education and research, and commitment to the needs of their respective communities.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

LEGAL MEDICINE

Due Process
The Massachusetts Medical Society calls for due process for physicians, including resident physicians, before any adverse action is taken by entities with whom the physician has a professional, contractual, or employment relationship to provide patient care.

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Item 1 of 2 Reaffirmed, MMS House of Delegates, 5/19/12
(Item 2of Original: Sunset)

The Massachusetts Medical Society will frame and support legislation to prohibit insurance companies from making material changes in existing signed agreements with physicians, particularly those changes that are deleterious to patients' interests, without giving prior written notification and a reasonable opportunity for 'meaningful' negotiations with individual physicians or their designees.

The Massachusetts Medical Society will frame and support legislation to require insurance companies to submit any disputes with physicians over material changes in existing provider contracts, particularly those changes that are deleterious to patients interests, to binding arbitration, if challenged.

The Massachusetts Medical Society encourages insurance and managed-care companies to negotiate contracts with physicians in fairness and good faith, without open-ended clauses and unilateral rights to amend.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Massachusetts Medical Society Administration and Organization

Boston Medical Library
The MMS will explore providing periodically scheduled educational courses that enable members to learn and practice commonly used medical literature search tools and documentation of source materials, and to enable members to access tools and technology that support timely access to electronic medical literature and patient safety information. *(D)*

The MMS will work with the Boston Medical Library (BML) to explore ensuring availability of full-time, dedicated medical reference librarian staffing through the BML, rotating between the BML-Countway and the BML Branch Library (at the MMS headquarters in Waltham), whose only work will be to assist MMS members, and, in collaboration with the MMS Department of Continuing Education and Certification, to:

- Work in person and remotely to help develop users' search skills
- Consult about and conduct literature searches
- Teach information literacy classes
- Collect, manage, and preserve relevant resources, tools, and technology (e.g., collection of sample search software) and serve as resource "troubleshooters" for members needing guidance and professional medical reference librarian expertise in identifying, extracting, and analyzing professional medical literature and patient safety information. *(D)*

The MMS will explore mechanisms to advocate for members to obtain expanded electronic access to more core medical journals. *(D)*

MMS House of Delegates, 5/19/12

The Massachusetts Medical Society (MMS) will continue its support for the Boston Medical Library (BML) and the Waltham branch of the BML/ Countway Library. *(D)*

The MMS will continue to increase its role with the BML and promote the library and access to its members and continue monetary and in-kind contributions to the BML, which in turn supports the continuation of the BML Branch services at MMS Headquarters. *(D)*

The MMS will continue to provide an annual "commitment of support" to the BML. *(D)*

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16

Budget
Programs or initiatives will be assigned a priority, and approved by the Board of Trustees.
*(*Amended and Reaffirmed MMS House of Delegates 5/9/08; Original Policy Sunset)*

Appropriate resources will be directed to program areas in order of priority.

The Board of Trustees will be delegated to assign a supplemental budgetary appropriation, action plan, and timeline for programs and initiatives.

Management will continue its work to achieve budgetary and operational savings and report to appropriate committees and the Board for guidance and approval.

The HOD may modify the priority list of the BOT and adjust the priority list with a super majority of a 2/3 vote of the House.

The BOT shall include in its report the total budget to be allotted to new programs approved by the HOD, and the HOD may modify this budget by a 2/3 majority vote.

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15

Charitable and Educational Fund

The original provisions of the Massachusetts Medical Society Charitable and Educational Fund, adopted by vote of the Council on October 5, 1955, and restated on October 13, 1982, be restated as follows:

MASSACHUSETTS MEDICAL SOCIETY
CHARITABLE AND EDUCATIONAL FUND
PROVISIONS

(1) The name of the fund shall be the "Massachusetts Medical Society Charitable and Educational Fund."

(2) The Fund is established exclusively for charitable and education purposes, including, for such purposes, the making of (a) grants and/or loans to qualified medical school students and (b) distributions to organizations that qualify as exempt organizations under section 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code.

(3) The Fund is to be administered by a Board of Directors, seven (7) in number, all members of the Society, five (5) of which shall be appointed by the president and approved by the House of Delegates of the Massachusetts Medical Society for terms of one, two, three, four, and five years initially and thereafter one each year. In addition, the Society's secretary-treasurer and chair of the Finance Committee, or chair's designate selected from the Finance Committee, shall be the directors ex-officio, with the right to vote.

(4) Any appointed directors may be removed by the president. In the event of any vacancy on the board, the president shall appoint a board member to complete the term.

(5) The Board of Directors shall have specific control over the Fund, including but not limited to, control over (a) investments made by the Fund, (b) the acceptance of bequests, legacies, contributions, gifts and loans in the name of the Massachusetts Medical Society, made to the Fund and (c) the specific distribution of income and/or principal of the Fund for charitable and educational purposes with such distributions being made by the Fund, drawing on the Fund's special account.

(6) No part of the net earnings of the Fund shall inure to the benefit of, or be distributable to, its members, trustees, officers or other private persons, except that the Fund shall be authorized and empowered to pay reasonable compensation for services rendered and to make payments and distributions in furtherance of its charitable and education purposes. No substantial part of the activities of the Fund shall be carrying on of propaganda, or otherwise attempting to influence legislation, and the Fund shall not participate in, or intervene in (including the publishing or distribution of statements) any political campaign on behalf of, or in opposition to, any candidate for public office. The Fund shall not carry on any other activities not permitted to be carried on (a) by a charitable and educational organization exempt from federal income tax under Section 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code, or (b) by a charitable and educational organization, contributions to which are deductible under Section 170(c)(2) of the Internal Revenue Code, or corresponding section of any future federal tax code.

(7) On an annual basis, the Board of Directors shall provide an informational report to the House of Delegates of the Fund's finances.

(8) Upon dissolution of the Fund, assets shall be distributed for one or more exempt purposes within the meaning of section 501(c)(3) of the Internal Revenue Code, or corresponding section of any future federal tax code or shall be distributed to the federal government, or to a state or local government for a public purpose. Any such assets not so disposed of shall be disposed of by the Middlesex County Superior Court exclusively for such purposes or to such organization or organizations as said court shall determine, which are organized and operated exclusively for such purposes.

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

Committees/Sections
The Massachusetts Medical Society create a Minority Affairs Section in order to represent underrepresented groups and communities across the membership. The section would be entitled to one delegate in the House of Delegates, and the delegate shall be elected by the section. *(D)*

MMS House of Delegates, 12/3/16
(Item 1 of 2:Pending Bylaw Amendment at A-17)

All requests for approval of committee continuance should include a brief written evaluation and recommendation by the Board of Trustees based on:

- How well the committee met its stated objectives
- Frequency of meetings and attendance
- Evidence of an effective work product
- Additional evidence (such as educational benefit, publications, increased membership, etc.)
- Reasonable cost to the Massachusetts Medical Society (MMS) for work performed
- Uniqueness of the committee (i.e., function not duplicated elsewhere in the Massachusetts Medical Society)

(D)

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

The Massachusetts Medical Society (MMS) supports the following principles and recommendations:
MMS Committee Structure Principles
The CSP shall:
a) Review the MMS committee structure every three years as warranted;
b) Develop a comprehensive action and communication plan for any committee structure changes;
The MMS shall:
c) Review committee productivity against committee action plans and current environmental/leadership needs, including the Society's strategic priorities;
d) Review a more comprehensive leadership and coaching process for the MMS leadership (including district, committee, and potential future leaders) regarding their responsibilities and leadership skills;
e) Explore, develop, and promote new methods for encouraging committee participation that will attract and retain members;
f) Prior to each Presidential Year, develop a comprehensive outreach communication plan to members and specific targeted populations to promote the work of the MMS committees.

MMS House of Delegates, 5/13/05
Amended and Reaffirmed MMS House of Delegates, 5/19/12

The Dean's Advisory Group will be available to advise on any major issue pertinent to any publication, at the request of either the editorial staff, the Society, or both, and that its role be advisory only, and that it report to the Committee on Publications.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/11/06
Reaffirmed MMS House of Delegates, 5/11/13

Committee on Senior Volunteer Physicians Health Center Program
The Massachusetts Medical Society will support and fund requests for professional liability insurance from physician volunteers that are approved through the Committee on Senior Volunteer Physicians Health Center Program. *(D)*

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

Conflicts of Interest Policy
The Massachusetts Medical Society (MMS) Policy Statement on Conflicts of Interest states:

POLICY STATEMENT ON CONFLICTS OF INTEREST

MMS delegates, trustees, officers, committee members, and agents assume a fiduciary duty to act in the best interests of MMS, as well as in accordance with applicable state and federal laws and regulations. A conflict of interest occurs when a delegate, trustee, officer, committee member, or agent has a material financial or beneficial interest which is likely to affect decisions made by or on behalf of MMS, or participates in other activities which significantly may impair the objectivity of or inappropriately influence the delegate's, trustee's, officer's, committee member's, or agent's decisions or actions on MMS matters.

It shall be the policy of MMS that its delegates, trustees, officers, committee members, and agents shall either abstain from participation in such MMS decisions or activities or shall make full disclosure of conflicts or potential conflicts of interest. Such disclosure shall be to the Board of Trustees in accordance with procedures which the Board shall from time to time adopt.

MMS Officers, during their term of office and for two years thereafter, shall not assume any administrative position with an organization for which MMS appoints, elects, or nominates officers and/or directors without the approval of the Board of Trustees.

The Board of Trustees procedures pertaining to conflicts of interest shall be implemented in a manner which is intended to be legally enforceable. Questions regarding application of this policy and the Board's procedures shall be resolved by the Committee on Administration and Management.

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

Cotting Luncheon
The Massachusetts Medical Society will continue to honor benefactor Dr. Benjamin Eddy Cotting by designating a luncheon at either the Annual or Interim House of Delegates meeting as the "Cotting Luncheon."

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

District Medical Societies
The Massachusetts Medical Society (MMS) will offer each of the following services to the District Medical Societies at cost through a charge-back system to the districts:

- Accounting services – including annual financial statement
- Tax preparation service
- Bookkeeping
- Non-profit tax disclosure regulation compliance (such as public inspection of tax returns)

No district is obligated to take advantage of services offered through the MMS, but each district is encouraged to utilize the expertise available through the Society if it would help the district operate more effectively.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Grants-in-Aid
The Grants-in-Aid program will be changed from an application and approval process to a maximum $5,000 grant given by the Massachusetts Medical Society annually to any district, upon request, for support of district activities.

The district participating in the Grants-in-Aid program annually will report back to the District Leadership Council as to the use of these funds.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Historical Preservation
The MMS's commitment to preserving and protecting its heritage will be an ongoing initiative and implemented in stages over time. *(D)*

The MMS will preserve and strengthen the collaborative relationship with the Boston Medical Library (BML) and the Center for the History of Medicine at the Countway Library of Medicine for the purpose of maintaining MMS and district historical records and artifacts. *(D)*

The MMS will continue its oral history program to preserve the contributions of past MMS presidents and other MMS leaders. *(D)*

The MMS will coordinate potential display opportunities of the history of the Massachusetts Medical Society (and its district medical societies), the oldest medical society in continuous existence in the United States. *(D)*

That, as part of its record retention policy, the MMS will include provisions to specifically address the preservation of documents being created now that will have historical value in the future. *(D)*

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

The MMS will focus its review and actions concerning historical documents on preserving and protecting the documents and artifacts of the MMS and its district medical societies. *(D)*

MMS House of Delegates, 5/9/08
(Items 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/2/15

House of Delegates
Electronic keypad voting will be used when:

- A voice vote at a House of Delegates (HOD) meeting is not obviously decisive to the Speaker
- A delegate calls for division (a counted vote) on a voice vote that is not obviously decisive
- A delegate calls for a counted initial vote

(HP)

The Speakers of the House of Delegates shall remind and educate delegates about a) their parliamentary right to call for a counted vote and b) that electronic keypads will be used for a request for a counted vote (division) or an initial counted vote. (D)

In order for a ballot vote to be taken by any method other than electronic keypads, a motion and approval by a majority vote shall be required, unless otherwise specified in the Bylaws or Procedures of the House of Delegates. *(HP)*
MMS House of Delegates, 5/17/14

The MMS will explore methods to allow online communication and collaboration for proposed HOD resolutions, including background information, among members prior to the release of the Delegates' Handbook. *(D)*
MMS House of Delegates, 12/4/10

The MMS will request that the districts work toward selecting delegates that better reflect the composition of practicing physicians in the Commonwealth (as registered with the Board of Registration in Medicine) by considering such factors as gender, specialty, age, and other demographics. *(D)*
MMS House of Delegates, 11/3/07
(Item 2 and 3 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/17/14

The Finance Committee of the Massachusetts Medical Society will review all regularly submitted and late resolutions that have a fiscal note of $5,000 or greater and make a recommendation as to the fiscal impact of each resolution to the House of Delegates.

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

That whenever possible, fiscal notes will be amended to reflect the recommendations of a reference committee in its report to the House of Delegates.

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

The Massachusetts Medical Society will reimburse delegates attending a meeting of the House of Delegates for the cost of their overnight accommodations for one night, if needed.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Leadership Development/Ambassador Program

The Massachusetts Medical Society will promote representation in its leadership and committees that reflects the Society's membership diversity, demographics, and gender. *(D)*

MMS House of Delegates, 12/3/16

The current criteria for selection of ambassadors and a coordinator for the program include the following:

1. The selected ambassadors will attend the AMA Annual Meeting, and fully participate by shadowing MMS delegates/alternates and attend all scheduled delegation meetings and House of Delegates sessions at the AMA Annual Meeting (currently beginning at 6pm Friday and concluding at noon Wednesday) unless the ambassador has reasonable alternatives that would benefit the Massachusetts AMA delegation and are approved by the ambassador program coordinator.
2. The applicant must be an MMS member and have indicated his or her willingness to serve, should they be selected.
3. The applicant must be nominated by one MMS member with an accompanying letter of support.
4. If necessary, the applicant and nominator may be required to be interviewed by the chair of the AMA Delegation and/or the coordinator of the Ambassador Program.
5. The applicant should never have attended a meeting of the AMA House of Delegates.
6. The selection decisions should be made by the AMA Delegation.
7. The selected ambassador(s) should later, in person or in writing, report to the MA AMA Delegation and the MMS House of Delegates (HOD) regarding their reflections on their experience within this program.
8. The coordinator and AMA Delegation chair will maintain an ongoing report to the HOD documenting the alumni, the history of the program, and the resultant effect as to its intended goal.
9. The MA AMA Delegation will select the coordinator from among the MMS elected delegates and alternates.
10. A maximum of five (5) ambassadors will be selected annually.

(D)

MMS House of Delegates, 12/4/10
Amended and Reaffirmed MMS House of Delegates, 12/1/12
Amended and Reaffirmed MMS House of Delegates, 5/17/14

The existing criteria for selecting nominees shall include: trustees or alternate trustees to the Board of Trustees (BOT), and/or chair, vice chair, or members of MMS committees, sections*, and/or district officers. *(D)*

The recruitment process will be expanded to include online, written, and personal outreach. *(D)*

The evaluation process for the Ambassador program will be expanded to include formal feedback from mentors, ambassadors, and the AMA delegation. *(D)*

MMS House of Delegates, 11/15/08
Item 3: Amended and Reaffirmed MMS House of Delegates, 12/5/09*
(Items 1, 2, and 4 of Original Sunset MMS House of Delegates, 12/1/12)
Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society (MMS) will continue its generous support of medical students by providing travel funding for students serving in official functions to attend the Annual and Interim Meeting of the American Medical Association (AMA) Medical Student Section (MSS).

The MMS-MSS Governing Council officers will choose four medical “student ambassadors” who are first-time attendees to attend the AMA-MSS Annual and Interim Meetings.

All medical students receiving funding to attend the Annual and Interim Meetings of the AMA-MSS from the MMS shall agree to sign and abide by the “Requirements for all AMA-MSS Meeting Attendees Funded by the MMS” developed by the MMS-MSS Governing Council, which outlines responsibilities of funded individuals and usage of funding.

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Item 3 of Original: Sunset MMS House of Delegates, 12/1/12)

Leadership Development
The Massachusetts Medical Society (MMS) will continue its support of leadership development by providing funds for registration and reasonable travel expenses, in accord with current Society policies on travel reimbursement for Society members on official business, for one medical student from each of the four Massachusetts medical schools, as selected by the Governing Council of the MMS Medical Student Section, to attend the American Medical Association Medical Student Advocacy Day.

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

MMS Leadership Initiative
The mission for the MMS Leadership Initiative shall be as follows:

- Identify core competencies of leadership and develop a program to enhance acquisition of these competencies by physicians who will provide leadership for the Society and its larger mission.
- Define those factors that shape the needs for physician leadership development in Massachusetts and the MMS.
- Explore diverse pathways and formulate a cost-effective, meaningful, high-quality program that will attract future leaders.
- Promote awareness of the program, encourage participation, identify potential leaders, and support their development.
- Propose a program that offers a vital forum and learning opportunities for physicians to enhance optimal approaches for effective patient care and medical progress.

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

Membership and Dues
The MMS will obtain secure and confidential race and ethnicity data for MMS members by utilizing all available sources, including third-party vendors, in order to understand the current composition of the MMS membership, and assist in the development of future goals. *(D)*

MMS House of Delegates, 12/3/16

The MMS approves the waiver of membership dues for medical school graduates eligible to apply for a graduate medical education program in the U.S. and who reside in Massachusetts and who have not been accepted into an accredited graduate medical education program. The approval for the waiver will be based on the request from the physician that shall be submitted annually, and is eligible for a period of up to five years after medical school graduation. The member status will change when a physician enters an accredited graduate medical education program.

MMS House of Delegates, 5/2/15

The MMS will work with the district medical societies to initiate consistent discounts for both state and district dues, which would provide simplification of the billing process and deliver more comprehensive invoices to the member. *(D)*

MMS House of Delegates, 5/21/11
(Item 1 of 3: Auto-Sunset)

The MMS will continue to seek to broaden the diversity of its membership and member participation in its activities. *(D)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

The MMS reinforces that its Code of Ethics is a standard of Society membership. *(D)*

MMS House of Delegates, 11/15/08
*(*for additional information, please see Informational Report: A-09 – 29, from the Task Force on Code of Ethics as a Standard)*
Reaffirmed MMS House of Delegates, 5/2/15

The Massachusetts Medical Society exempts dues for residents who enroll as part of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) accredited residency training programs.

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

The Massachusetts Medical Society (MMS) will exempt dues for its Medical Student Membership. *(D)*

In order to offset expenses of exempt dues for Medical Student Membership, an alternative level of benefits will be provided for medical student members, including substitution of the *New England Journal of Medicine* (NEJM) *Online* for the printed NEJM subscription, and that medical students will no longer have MMS Internet account privileges. *(D)*

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

The MMS shall continue its efforts to further enhance its image with key constituencies, including patients and physicians.

The MMS shall continue working with the American Medical Association (AMA) to build AMA membership and to enhance the image of organized medicine in Massachusetts.

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12

The MMS will institute the following initiatives to encourage large group practice and other health care organization physicians to become members:

- Identify current MMS members in large group practices and other health care organizations to serve as “in-house” recruiters and establish on-going recruitment programs within each entity.
- Work with the administrations of large group practices and other health care organizations to provide newly-hired physicians with MMS membership information, as well as ensuring that membership recruitment materials are available to all physicians within these entities.
- Implement a group dues billing system that will allow the administrators of large practices and other health care organizations to receive a "super bill," listing all MMS members within the practice and allowing for the payment of their dues with one check.
- Work to ensure that there are regular opportunities for MMS representatives to make membership presentations to the staffs of large group practices and other health care organizations.
- Recruit group practice and other health care organization physician representatives to serve as members of the MMS Organized Medical Staff Section and ensure their active involvement.

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
(Bullet 5 of Original:, Sunset)

The House of Delegates delegates to the Board of Trustees the authority to approve the use of pilot membership recruitment/retention projects involving variations of no more than 50% on the current MMS dues structure, as proposed by the Committee on Membership.

Such pilot projects shall be required to have a defined time limit, as well as having the prior approval of the Committee on Finance.

The Committee on Membership shall report annually to the House of Delegates as to the impact of all current pilot projects.

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

The MMS strongly emphasize to its members the very important work Physician Health Services (PHS) does and highlight the fact that PHS is supported largely by charitable donations. *(D)*

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society (MMS) encourages Physician Health Services (PHS) to respond to the needs of physicians who have witnessed and/or participated in atrocity-producing situations. Such a program might involve outreach, triage, intervention, treatment, and/or referral to other existing services, and provide an environment in which physicians might explore options to prevent future ethical compromise.

The MMS will advertise via internal communications venues, where such advertising is appropriate and possible, assistance for physicians who perceive themselves to have been witnesses or participants in atrocity-producing situations.
(D)

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

The House of Delegates votes to increase the Board of Trustees' role as sole voting member with respect to Physician Health Services, Inc.

The House of Delegates votes to delegate to the Board of Trustees the authority to act for and on behalf of the Massachusetts Medical Society in its capacity as sole voting member of Physician Health Services, Inc., in all matters which, by law, the Articles of Organization of Physician Health Services, Inc., or the bylaws thereof require action by the sole voting member, including, but not limited to amendment of the said Articles or bylaws, except that such delegation of authority shall not be construed as extending any power which the House of Delegates is prohibited from delegating and provided that the actions of the Board of Trustees in this capacity as sole voting member shall be reported to the House of Delegates.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

The Massachusetts Medical Society encourages physicians to continue to take immediate initiative in diagnosing drug/alcohol abuse as early as possible in the disease process to prevent job and family impairment, and make appropriate intervention with treatment and education of the individual patient. The Massachusetts Medical Society voices its commitment to involve physicians in finding solutions to the complex medical and social problems of substance abuse and encourages physicians to work with other concerned community agencies drawn from such fields as law, social work, psychology, education and religion.

MMS Council, 10/8/86
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Policy Resources and Tracking

The MMS Board of Trustees or its designated agents will develop an informational report that would be presented at each House of Delegates meeting that:

a. Those reports and resolutions that thus far are not funded or partially so
b. Stands alone as a report with an appropriate title, which is not to be contained within a more lengthy report (e.g., the budget)
c. Updates prior such nonfunded or partially funded reports and resolutions
d. Supplies the links or hyperlinks to the entire verbiage of above-mentioned reports or resolutions to ensure the responsibility of the House of Delegates to restudy the appropriateness and support of these decisions
e. Includes the reasoning (financial, legislative, etc.) for this status and decision. *(D)*

MMS House of Delegates, 5/14/10

Publishing Division

The Delegates affirm that their Committee on Publications and the leadership of the Society continue to use due diligence in avoiding inappropriate commercial arrangements that might damage the professional reputation of the Society of *The New England Journal of Medicine*, or the Society's other publications.

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

The Editor-in-Chief of *The New England Journal of Medicine* (*NEJM*) shall continue to enjoy complete editorial independence.

Any print or electronic publication entitled *The New England Journal of Medicine* or identified as coming from the editors of *The New England Journal of Medicine* shall fall under the responsibility of the Editor-in-Chief.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The Delegates express their continued confidence in the integrity and judgment of the Committee on Publications, the Board of Trustees, and the Society's Officers, and recommend that the Society continue appropriate policy with respect to new publishing and medical information ventures commensurate with the Society's resources and committee structure.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The following vision statement shall guide the Massachusetts Medical Society (MMS) publishing activities:

The MMS will continue to be a leader in publishing authoritative information on health care and health sciences. Through its Committee on Publications and Publishing Division, the Society will "…do all things as may be necessary and appropriate to advance medical knowledge…" as first defined in its Act of Incorporation (Chapter 15, of the Acts of 1781, as amended). The Society will maintain the recognized level of excellence and credibility of its publications in the scientific, medical, and public domains throughout the world.

The principal objectives of its publishing activities is to advance biomedical science and to educate physicians, other healthcare professionals, and the public. New developments will be encouraged in response to changes in educational and scientific needs and the availability of new publishing technologies. This will be accomplished in a manner that advances biomedical science and upholds the integrity and financial ability of the Massachusetts Medical Society to carry out its mission. The Society will conduct its publishing activities in a supportive and collaborative environment.

MMS will protect the editorial freedom and independence of all its publications intended primarily for external audiences. The Society will continue to pursue its mission with an abiding commitment to maintaining the excellence and preeminence of *The New England Journal of Medicine.*

The MMS House of Delegates shall review and affirm the publishing vision statement annually as prepared by the Committee on Publications.

Acts of Incorporation and Bylaws Updated as of May 1998
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Sections

The Massachusetts Medical Society (MMS) encourages each hospital medical staff in the Commonwealth to include at their regular meetings a report from a member of the medical staff in a leadership position of the district or state society that would provide timely details of events, activities, and issues pertaining to organized medicine.

The MMS will provide assistance to such representatives in their preparation of these reports pertaining to organized medicine for hospital medical staff meetings.

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

The Massachusetts Medical Society will reimburse medical student and resident members a reasonable amount for travel that pertains to official Massachusetts Medical Society business, particularly for travel to and from committee meetings (and the like) of which the student or resident is a member.

The medical student and resident reimbursement for travel be an appropriate amount for miles traveled, tolls, and (reasonable) parking fees.

Medical student and resident reimbursement for travel not imply indemnification for motor vehicle accidents.

The Board of Trustees shall be charged with the establishment of criteria for medical student and resident reimbursement of travel.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Strategic Direction
The MMS strategic priorities for 2016–2017 include the following: increase focus on population health, enhance patient experience, deliver cost effective care, and improve the quality of work life of the health care team. In order to advance the mission of the MMS and prepare for the future needs of the physician community and their patients, the goals of our strategic plan will be the following:

- *Physician advocacy*: Ensure the MMS is a productive and credible voice at the state and federal level for physicians in any practice environment or setting. The MMS will continue to carefully monitor the impact of the rapidly transforming health care delivery system on physicians and their patients, and identify and develop appropriate strategies as needed.
- *Patient care advocacy*: Work to identify and minimize barriers to access to the highest quality of cost-effective care. The MMS will continue to support the use of accurate, reliable, timely, and meaningful quality and cost data, in a manner that meets physician expectations for transparency and is constructive toward delivering the best care to patients.
- *Enhanced Membership Value*: Ensure the Society is positioned internally and externally to meet the changing needs of its members. The MMS will continue to advocate for a health care environment that safeguards the integrity of the patient-physician relationship, and promotes physician-led team-based care and professional satisfaction.

(HP)

MMS House of Delegates, 5/7/16

The Massachusetts Medical Society's strategic priorities for 2014–2017 are the following: improve health care quality, access, equity, and cost-effectiveness for the Commonwealth and promote a sound public health system. The goals for our strategic plan rooted with the long-term objective of quality improvement and the effective control of health care costs include:

- Playing a leadership role in developing a sustainable model of health care delivery that will preserve the integrity of the doctor-patient relationship, and ensure the best care for patients, which is at the core of patient centered care.
- Advocating for practice viability and ensuring physician professionalism, including the fair practice of clinical and economic integration, appropriately funded mandates, professional liability reform, a sustainable physician workforce, and an optimal practice environment.
- Preservation of professionalism: Advocacy for health care environments that foster a culture of professionalism to ensure patient-centered, physician- led care; promote professional satisfaction and meaning, and provide an optimal educational and training environment for the next generation of physicians.

(HP)

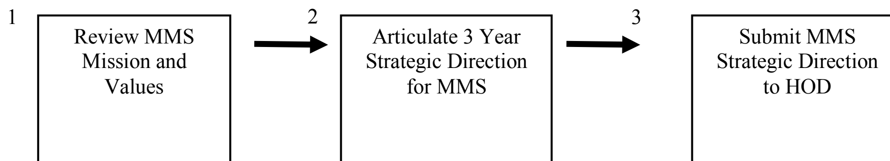
MMS House of Delegates, 5/17/14

The MMS approves the Framework for Strategic Planning as presented in Chart 2 (Next page).

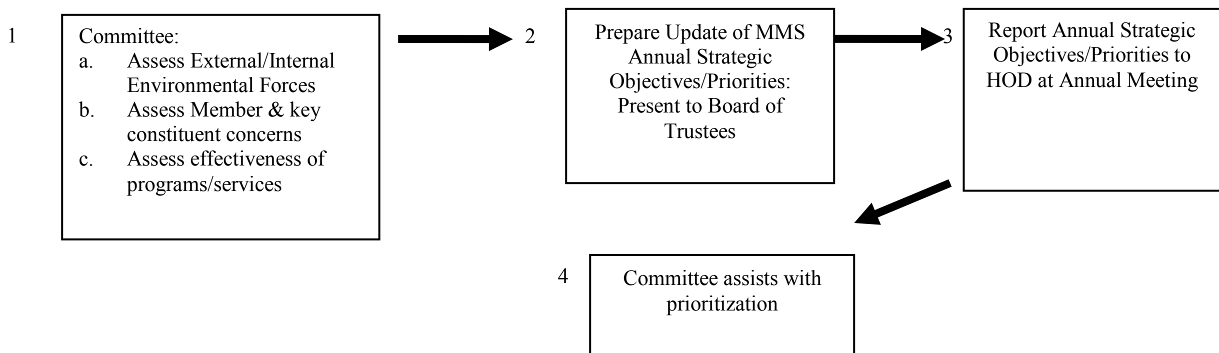
Massachusetts Medical Society

Framework for MMS Strategic Planning

MMS Planning Process – Every 3 Years



Annual Strategic Planning Process



MMS House of Delegates, 5/31/02
Framework Amended and Reaffirmed MMS House of Delegates, 5/2/03
(Chart 1 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/14/10

The Massachusetts Medical Society (MMS) reaffirms the purposes of the Society as outlined in Section 2 of the Act of Incorporation of the MMS, Commonwealth of Massachusetts, Chapter 15 of the Acts of 1781 as amended in 1969, which reads as follows:

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

The MMS reaffirms the statement of strategic direction for the Society adopted by the House of Delegates on November 6, 1996 which reads as follows:

> The Massachusetts Medical Society will continue to be a proactive organization. We will advocate for the shared interests of patients and our profession. We seek to unite all physicians and serve the common interests of the profession. Our goals are to enhance and protect the physician-patient relationship and to preserve the physician's ability to make clinical decisions for the benefit of patients. The Society will continue to encourage the development of standards for high quality care. We will continue to promote our code of ethics to physicians, patients, and the public. We will work collaboratively within the profession and with the public. The Society will address the professional needs of physicians and take a leadership role in the development of health care policy. We will promote medical education, training, research, and the continuing education of physicians. We will

communicate clearly and effectively with our members and the public to build awareness of and support for our goals.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
MMS House of Delegates, 5/11/13

Volunteer Vouchers

Volunteer vouchers for MMS-sponsored educational programs will be allowed to roll over for two fiscal years. *(D)*

MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15

MEDICAID

Eligibility Criteria and Enrollment

The Massachusetts Medical Society (MMS) will advocate for improved health care coverage for the needy in this state through initiatives, including, but not limited to:

- Continuing aggressive outreach programs to ensure 100 percent health care coverage for the children of Massachusetts
- Assuring that enrollment criteria for Medicaid remain at the highest eligibility level that allows for federal financial participation, and to continue the broadest possible inclusion of participants

(D)

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

MassHealth Program

The MMS will advocate for legislation in Massachusetts to require the state's Medicaid program, MassHealth, to institute pay parity, requiring Medicaid rates to remain at least as high as Medicare rates for the same services. *(D)*

MMS House of Delegates, 12/5/15

The Massachusetts Medical Society will work with the Massachusetts Division of Medical Assistance (MassHealth) to revisit the MassHealth drug list and prior authorization process so that patient well-being is not compromised. *(D)*

MMS House of Delegates, 11/8/03
MMS House of Delegates, 5/14/10

Preauthorizations

The Massachusetts Medical Society recommends to the Division of Medical Assistance that any requirements for preauthorizations by physicians be reviewed by MMS prior to implementation.

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Amended and Reaffirmed MMS House of Delegates, 5/21/11

Sterilization

The Massachusetts Medical Society supports and works to achieve the right of men and women in the MassHealth program to a reasonable waiting time between consent and procedure for sterilization, and that they be accorded the same autonomy as privately insured individuals.

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

Medical Education

Accreditation Council for Continuing Medical Education (ACCME)

That the Massachusetts Medical Society adopts the Accreditation Council for Continuing Medical Education Updated Accreditation Criteria, as amended from time to time, as a means to ensure that continuing medical education contributes to patient safety and practice improvement and is based on valid content independent of commercial interests. *(HP)*

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

The Massachusetts Medical Society adopts the Accreditation Council for Continuing Medical Education (ACCME) Standards for Commercial Support, as amended from time to time, as a means to ensure independence of CME activities. *(HP)*

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

Albert Schweitzer Fellowship Program

The Massachusetts Medical Society (MMS) and the Albert Schweitzer Fellowship (ASFP) will cooperate on an ongoing basis to support the professional development and service activities of-students attending Massachusetts medical schools, in keeping with the ideals of professionalism embodied by both organizations.

The MMS and the ASFP will share responsibilities for selecting and supporting the training of medical student participants in the ASFP with an emphasis on encouraging statewide participation.

The MMS and the ASFP will foster participation of Schweitzer Fellows and Alumni, MMS members, and students attending Massachusetts medical schools in each organization's activities and projects.

The MMS and the ASFP will collaborate in sponsoring public events, including the four public symposia conducted annually by each year's group of Schweitzer Fellows, that will highlight the accomplishments and commitment of both organizations in applying the highest ideals of the medical profession towards emerging health care issues.

The MMS will provide $25,000 annually to ASFP to support ASFP fellowships for students attending Massachusetts medical schools. Funding will be subject to an annual evaluation and approval by the Board of Trustees.

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

Care for Persons with Intellectual Disability/Developmental Disability

The MMS will provide appropriate continuing medical education opportunities that address medical care of persons with Intellectual Disability/Developmental Disability (ID/DD) and will be accessed voluntarily by MMS members. *(D)*

The MMS will provide web-based information to MMS members on resources and reference information on medical care of persons with ID/DD. *(D)*

MMS House of Delegates, 5/7/16

Continuing Medical Education Accreditation

It is the policy of the MMS to hold its accredited providers responsible for submitting required documentation and fees by the mandatory due date in order to maintain continuing medical education accreditation.

If the submission of the required documentation (application or interim report) and/or fees are not received by the first CAR meeting after the deadline, the MMS may take action to change the accredited provider's accreditation status to probation.

If, at the second CAR meeting after the deadline, submission of the required documentation (application or interim report) and/or fees has not been received, the MMS may take action to change the accredited provider's accreditation to non-accreditation.

The Massachusetts Medical Society will continue its efforts to be increasingly geographically and financially democratic in bringing its educational offerings to all members of the Massachusetts physician community.

MMS House of Delegates, 5/19/00

Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/2/15

Educational Debt
The MMS will pursue the following in regard to educational debt reduction:

- Endorse the "Primary Care Student Loan Demonstration Project"
- Advocate for other lenders' constructive revision of loan repayment terms, such as income-contingent loan programs
- Support any legislative effort to prolong the deferment period for educational loans through residency and fellowship
- Support legislative efforts to alter the eligibility requirements for allowing interest from educational loans to be an income tax deduction from a flat-income level to a ratio of debt to income

(D)

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 2-3 of Original: Sunset)

That our Massachusetts Medical Society shall support efforts to seek educational debt relief through the American Medical Association.

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

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

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

MMS House of Delegates, 5/21/11

That our MMS work with the AMA and the Accreditation Council for Graduate Medical Education (ACGME) to make training in end-of-life care a Residency Review Committee (RRC) requirement for all residencies in which such training holds relevance.
(D)

MMS House of Delegates, 11/3/07
Item 1 of 2: Reaffirmed MMS House of Delegates, 5/17/14
(Item 2 of Original 2: Sunset)

The Massachusetts Medical Society will work with the Massachusetts Hospital Association to study the best way to provide facilitated and informed decision-making by patients, their proxies, and their families regarding responses to code status, end-of-life, and life sustaining treatment. *(D)*

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

MMS House of Delegates, 5/11/13

The MMS will sponsor ongoing continuing medical education opportunities that address end-of-life care and pain management and their implications for risk management, and host a section on the MMS website for resources and reference information on these topics. *(D)*

MMS House of Delegates, 12/3/06
Item 2 of Original 2: Reaffirmed MMS House of Delegates, 5/11/13
(Item 1 of Original 2: Sunset)

Graduate Medical Education
The MMS will continue its efforts to secure Graduate Medical Education (GME) funding through our Congressional Delegation and coordinate those efforts with the American Medical Association.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society (MMS) establishes as policy its position that all physicians and medical students should be evaluated for the purpose of entry into graduate medical education (GME) programs, licensure, and hospital medical staff privileges solely on the basis of their individual qualifications, skills, and character.

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

The Massachusetts Medical Society advocates that all payors reimburse the supervising teaching physician for services provided by a resident unless that resident's service is already fully and explicitly funded by that payor.

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

LGBT Students and Patients
The Massachusetts Medical Society (MMS), as a three-year pilot, will annually offer a grant of up to $4,000 for medical students, residents and/or fellows from different institutions in the state to be used for curriculum development or to produce research that addresses lesbian, gay, bisexual, and transgender health disparities. Total MMS allocation will not exceed $16,000 per year. *(D)*

That LGBT Research Grant recipients will present their curriculum or research annually to the MMS with distribution to our membership. *(D)*

Procedures for administration of the LGBT Research Grant(s) shall be determined by the Board of Trustees. *(D)*
MMS House of Delegates, 12/6/14

The Massachusetts Medical Society encourages all medical schools in Massachusetts to consider the recommendations released by the Association of American Medical Colleges (AAMC) Group on Student Affairs (GSA), the AAMC Organization of Student Representatives (OSR), and American Medical Association policy and address areas in their curricula that require updating to meet these recommendations relative to incorporating lesbian, gay, bisexual, and transgender (LGBT) student and patient needs.
MMS House of Delegates, 12/1/12

State-Funded Medical School
The Massachusetts Medical Society (MMS) recognizes the importance of having a state-funded medical school in Massachusetts to provide a high-quality, but lower-cost option for residents of the Commonwealth to obtain a medical education.

The MMS will express to the Governor and the Massachusetts Legislature the advantages of having a publicly- funded medical school to benefit the residents of the Commonwealth of Massachusetts.

The MMS strongly urges the Governor and the Massachusetts Legislature to maintain the University of Massachusetts Medical School's status as a public institution supported in part by state funding.

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

MEDICAL RECORDS/ELECTRONIC HEALTH RECORDS

Clinical Data Repositories

A: The MMS adopts the following as Principles for Clinical Data Repositories (CDRs):

1. Clinical Data Repositories (CDRs) are beneficial for patients and physicians to improve the quality, safety, efficiency, and value of medical care for at-risk patients. The development and use of CDRs — following the appropriate privacy and security regulations — should be embraced and encouraged.
2. The Society should seek to bring the benefits of CDRs to physicians across the state, including primary care physicians and specialists in solo practice, small groups, and large groups.
3. Substantial resources will be required to sustain and increase the usefulness of CDRs over time. Public/private partnerships should be encouraged and duplication of effort avoided.
4. Massachusetts benefits from the continued collaboration of public and private organizations — such as the MMS, Massachusetts Hospital Association, Massachusetts Health Quality Partners, Massachusetts e-Health Collaborative, New England Healthcare EDI Network, Massachusetts Health Data Consortium, Massachusetts Technology Collaborative, commercial payers, MassHealth, and the Massachusetts Health Care Quality & Cost Council — to build the information infrastructure for our health care system. CDRs form a part of that continuum of development. Massachusetts' all-payer claims database overseen by the Center for Health Information and Analysis, has valuable information to inform policy development and help improve outcomes.
5. The Society should encourage all public and private payers to share data to enable CDR deployment and to enable the comparison of outcomes and processes among physician groups and patient populations.
6. Adoption of common data standards and definition of important clinical outcomes at the state and national level are ongoing processes necessary to achieve maximum value of CDRs for all constituencies.

(D)

MMS House of Delegates, 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
**(Item B5 of Original: Sunset)*
(Complete Item B of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/2/15

Electronic Health Records

The MMS will work with appropriate government entities to foster EHR innovation, affordability, and functionality by modifying the certification process for EHRs to improve patient care. *(D)*

The MMS will encourage the Office of the National Coordinator for Health Information Technology (ONC) to define HIT standards that can be freely used by HIT vendors/innovators to exchange medical information between EHRs and other HIT tools. *(D)*

The MMS will encourage the ONC to maintain a public website where physicians, innovators, and vendors can assess the ability of their EHR (and other HIT tools) to exchange information with other EHRs (and other HIT tools) in accordance with the ONC's recommended standards. *(D)*

MMS House of Delegates, 12/3/16

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

The MMS will continue to make a priority the following principles of electronic health records (EHR): the promotion of EHR interoperability, data portability, and health IT data exchange testing with the Office of the National Coordinator for Health Information Technology's (ONC). *(D)*

The MMS will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if the institution withdraws its support of EHR sponsorship. *(D)*

The MMS will advocate for EHR vendors to provide transparency of actual costs of EHR implementation, maintenance, and interface production. *(D)*

The MMS will support AMA efforts to work with the Centers for Medicare and Medicaid Services (CMS) and the ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs. *(D)*

MMS House of Delegates, 5/7/16

The Massachusetts Medical Society will appoint a task force to determine whether to encourage federal and state legislators and the Centers for Medicare and Medicaid Services to create regulations, legislation, and significant and compelling incentives and disincentives for all electronic health record (EHR) vendors to rapidly enhance their current EHRs to be able to do the following:

- Enable universal interoperability, standardization, and portability so that comprehensive patient health information can be transferred easily, accurately, and securely from one EHR system to another; for individual patient records and/or reports, for large batches of patient records, or for collections of patient data for research or quality reporting; and

- Provide each EHR with a user-friendly interface; and

- Design a format that allows easy access to both comprehensive summary of information on one page with efficient access to the details from that page to all related information; and

- Build comprehensive dictionaries, word completion, and customizable standard text to enable rapid access to specific medical terminology, which will facilitate rapid entry of data; and

- Provide systems to efficiently manage prevention, quality, and chronic disease management for individual patients and populations of patients using EHRs, including the ability to allow physicians to run customized reports; and

- Provide systems to report quality and performance measures efficiently, accurately, securely and electronically for Meaningful Use, PQRS, and other federal and state quality programs; and

- Provide efficient, accurate, secure export systems to facilitate research from data stored in EHRs.

(D)

MMS House of Delegates, 5/2/15
Amended and Reaffirmed MMS House of Delegates 5/7/16

The MMS will establish or enhance current member-directory services to include a member's Direct certificate, including functionality that enables each member to choose where to receive Direct secure messages. These destinations may include EHRs, health information exchanges, and other services that the MMS may develop. *(D)*

The MMS will manage the issuance and support of certificates that conform to Federal Bridge CA standards independent of any particular employer or EHR vendor. *(D)*

MMS House of Delegates, 5/17/14

The MMS will research and develop clear guidelines, best practices, and ongoing education regarding the effective use of electronic health records (EHR)/health information exchange (HIE) technologies based on appropriate information.

Subjects should include but not be limited to:
- Analysis of time management before and after EHR adoption
- Quality of practice after EHR implementation
- Amount of time required to complete a high-quality medical record per patient
- Guidelines for preparing effective and appropriate notes for primary care and specialists using technology tools
- Reimbursement before and after use of an EHR
- The effects of various reimbursement models on electronic workflow
- Quality of practice before and after EHR implementation
- Utility of employing medical scribes
- Confidence in coding using an EHR
- Use of templates and whether information is truly entered because of its importance to patient care versus its importance to complying with billing and coding mandates
- The use of "pertinent negatives" and the amount of data that is carried forward to save time and improve coding, but in fact is not addressed at the time of the visit
- Legal and liability issues surrounding the exchange of protected health information (PHI)
- Guidelines for communicating electronically with patients
- Physician suggestions for EHR technology improvement
- Effects of coding on the usability of both entering and reading and usefulness of EHRs

- Experience with free and low-cost cloud EHRs such as the VA VistA system, and explore the benefits, risks, availability, and usability of open source EHRs.
- Best practices for managing patient privacy, opt-in, and obtaining records.

(D)

The results of the research on electronic health records and health information exchange will be distributed widely using low-cost electronic means. (D)

MMS House of Delegates, 12/1/12

The MMS will consider filing legislation that would bring clarity and consistency to the process of minors' consent and/or assent related to health information exchange. *(D)*

MMS House of Delegates, 11/15/08
(Item 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/2/15

The MMS will provide members with unbiased information based on practical working electronic health record (EHR) installations that reflect members' needs. *(D)*

The MMS will provide a broad educational program to help physicians transition to EHRs successfully. *(D)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Item 4 of Original :Sunset, Time-Limited Directive)
(Item 1 of Original: Sunset)

Opt-Out: Consent/Information Sharing

That the Massachusetts Medical Society will proactively work with appropriate stakeholders to change the Massachusetts consent process for sharing health information to a simple opt-out process for patients who do not wish to share their health or medical information with other providers caring for them. *(D)*

MMS House of Delegates, 5/7/16

The MMS will explore ways to help our members own and share aggregated practice performance data to include claims-based and clinical information. *(D)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 1 and 2 of Original: Sunset)

That the Massachusetts Medical Society (MMS), in cooperation with the Massachusetts eHealth Collaborative, study and report on the potential value of electronic health records (EHRs) and electronic health information exchange in terms of quality, efficiency, and safety and the impact on each stakeholder and develop the following:

- Recommendations as to which of the health care stakeholders might reasonably be expected to contribute financially to creating and sustaining such an EHR network.

- A reasonable yet comprehensive business model for deploying and sustaining EHRs and health information networks.

- Reasonable resources to disseminate and promote the recommended model on EHRs and health information networks to facilitate and ensure widespread adoption.
  (D)

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

The Massachusetts Medical Society (MMS) will advocate for equitable cost sharing through government subsidies, and/or assistance from insurance carriers, and/or health care entities for purchasing and adopting Electronic Health Record (EHR) technology in physicians' offices so long as they are able to interface with the majority of subsidized EHRs. *(D)*

The MMS will be directed to include in its proposals measures for equitable cost sharing through government subsidies, and/or assistance from insurance carriers, and/or health care entities for adopting EHR technology in physicians' offices. *(D)*

The MMS supports independence of physicians to choose their own EHR systems or be offered a choice by entities providing subsidies or assistance for purchasing these systems. *(HP)*

The MMS promotes the principle that physicians remain free to choose what protected health information may or may not be shared with the hospital or entity providing support for these systems, consistent with current law, as well as the physicians' and patients' wishes. *(D)*

That, within the constraints of the law, the MMS will advocate with health plans and government entities to consider the costs of implementing EHR technology and the ongoing costs of its maintenance, training, and support in the practice expense component of the RBRVS (Resource Based Relative Value System) formula. *(D)*
The progress on the issue of equitable cost sharing of EHRs will be reported to the House of Delegates at every Interim and Annual Meeting. *(D)*

MMS House of Delegates, 12/3/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed (Items 1-3 of Original 5) Amended and Reaffirmed, MMS House of Delegates, 5/7/16

The Massachusetts Medical Society will work with appropriate organizations (including the American Medical Association, specialty societies, and patient advocacy groups) to ensure that the clinical data-exchange standards on which a National Health Information Network and Regional Health Information Organizations are based are subject to approval and ratification by these organizations and end-users such as physicians and patients. *(D)*

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

The MMS will work with appropriate entities to improve the functionality and value of EMRs for physicians and their patients, with the goal of enhancing health care quality, safety, and efficiency. *(D)*

MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
(Items 1 and 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16

It is the policy of the Massachusetts Medical Society (MMS) that the clinical information contained in the Electronic Health Records (EHRs) be in a standardized format with nonproprietary, affordable exportability. *(HP)*

The MMS will advocate to our federal representatives for legislation that requires all EHR vendors that are participating in federally funded programs or that have been approved by federally funded programs to make the clinical information contained in EHRs exportable in a standardized, nonproprietary format and to make EHRs capable of importing clinical data in this standardized format. *(D)*

MMS House of Delegates, 11/6/04
Item 2 of Original 2: Reaffirmed, MMS House of Delegates, 5/21/11
Item 1 of Original 2: Reaffirmed MMS House of Delegates, 5/19/12
Item 1 of Original 2: Amended and Reaffirmed MMS House of Delegates, 5/7/16

MEDICARE/MEDICAID SERVICES

Funding
The MMS supports appropriate tax policy to ensure that Medicare is adequately funded. *(HP)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Item 2 of Original 3: Reaffirmed MMS House of Delegates, 5/7/16
(Items 1 and 3 of Original: Sunset)

MassHealth
The Massachusetts Medical Society (MMS) will advocate with appropriate government entities to ensure that, consistent with the intent of federal law, the Medicare fee schedule be an absolute minimum floor for services provided to MassHealth patients. *(D)*

The MMS will pursue adequate medication coverage for MassHealth patients that does not interfere or intrude on the doctor-patient relationship when reasonable clinical documentation of medical necessity is provided. *(D)*
MMS House of Delegates, 12/5/09
Reaffirmed MMS House of Delegates, 5/7/16

Practice Expenses
HCFA [CMS] should make efforts to broadly survey medical practices for actual expense data.

The complex surveys needed for practice expense determination should be funded, reimbursing contributing practices for their time and effort.

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

MENTAL HEALTH

Mental Health Services
The MMS will advocate for patients to ensure that they have ready access to appropriate mental and behavioral health care. *(D)*
MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Items 1-4 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/7/16

Mental Health Services: Gestation and Postpartum
The MMS supports a culture of awareness, destigmatization, and screening for psychiatric illnesses during gestation and postpartum to ensure that patients have access to effective and affordable mental health services. *(HP)*

The MMS will advocate for expanding health insurance coverage and reimbursement of medically necessary mental health services during gestation and postpartum. *(D)*

The MMS will work with other appropriate organizations and specialty societies to support and promote awareness among patients, families, and providers of the risks of mental illness during gestation and postpartum. *(D)*

The MMS will work with all appropriate parties such as insurers, health care systems, providers, consumers, allied health care professionals, and the government to foster integration of mental health care with general medical care.

MMS House of Delegates, 12/3/11

Mental Health Services Principles
The Massachusetts Medical Society (MMS) does not support mental health carve-out arrangements for the provision of behavioral health services because of concerns regarding the impact of carve-out arrangements on patient access to high-quality health care. These concerns include fragmentation of the medical and mental health care systems; overly aggressive management techniques; serious threats to patient confidentiality; and the reduction in the role played by primary care physicians (PCPs) in diagnosing and treating mental illness and managing the patient's overall health.

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

READY ACCESS TO PERSONALIZED MENTAL HEALTH REFERRALS

- Provide appropriate and timely diagnosis, assessment, and treatment of behavioral health illnesses.
- Employ locally based management, medical, and other professional personnel familiar with the providers and facilities in the contracted network.
- Make available and widely disseminate a provider network list and access information to enrollees through several mechanisms that include phone, fax, paper and Web access.
- Allow patients to be easily linked to appropriate providers accepting new patients.

MEANINGFUL INTEGRATION WITH THE MEDICAL CARE SYSTEM

- To maximum extent possible, encourage the natural referral patterns between PCPs and psychiatrists through active outreach to PCPs, hospitals and medical groups.
- Open networks to qualified mental health providers with relationships with PCPs.
- Encourage clinical collaboration between PCPs and psychiatrists in the planning, authorizing and delivering of intensive psychiatric services, such as inpatient services, day treatment, and medically necessary psychotherapy.

COMPLIANCE WITH THE PRINCIPLES OF PARITY

- Review and authorization processes should be no different than those for physical illness.
- Insurance company administration should be accessible to providers and patients to the same degree for medical and mental health services. If medical services are administered locally, so should mental health services.

STRICT CONFIDENTIALITY AND SENSITIVITY TO STIGMATIZATION

- Maintain an acute awareness that patients often feel stigma in seeking mental health services. Because of this, there must be strict adherence to confidentiality, active efforts to insure patient dignity and elimination of potential barriers to service, such as voice mail mazes, unnecessary intake questions and difficulty accessing providers.
- Use appropriately trained and supervised case managers and screeners, with relevant and age-group-specific psychiatric or addiction medicine training, and not lay individuals, to authorize access to behavioral health services.
- To protect the privacy and confidentiality of a patient’s records, only the patient information necessary to confirm the need for behavioral health care should be elicited.

STREAMLINED AUTHORIZATION & CONTINUING REVIEW PROCEDURES

- Use evidence-based criteria for authorization of continuing care in managed care plans.
- No prior micromanagement of type of visit: Psychiatrists should determine the length and type of visit according to their clinical assessment, which includes automatic authorization of initial phases of treatment. Psychiatrists should also have access to Evaluation and Management codes due to the wide range of services that are provided during behavioral health care visits.
- Eliminate unnecessary review of routine care, such that when a cap on the number of mental health visits is imposed, recertification for additional visits should be considered upon request by the treating psychiatrist or other health care professional without additional personal information from the patient.
- Allow immediate internal appeal by a physician for denials of service and make readily available third-party review of denials for seriously ill psychiatric patients.
- Eliminate burdensome, redundant, and not clinically useful paperwork.

AVAILABILITY OF INTENSIVE SERVICES TO THE SERIOUSLY PSYCHIATRICALLY ILL

- Establish easy availability of case management services for patients with complex mental health needs.

- Provide easy access to medically necessary inpatient services, with the awareness that inpatient services may be required for patients who are seriously psychiatrically ill but do not meet dangerousness criteria necessary for involuntary commitment.
- Make available inpatient services which are close to a patient's home.
- Provide easy access to appropriate, locally based day treatment services.

ONGOING AND ANNUAL ASSESSMENTS

- Implement ongoing assessment of the needs of the patient population in compiling specialty and subspecialty network to ensure that access will be available to patients.
- Actively assess ease of access of referrals and reasons patients elect to opt out of network resources; share assessment results with purchasers of health care.
- Encourage contracts for behavioral health care that meet standards of recognized private sector accrediting bodies and share such information with patients.
- Ensure transparency of the flow and accountability for health care dollars, in order to assess what proportion of the enrollees' premium is paying for medical vs. non-medical costs.
- Encourage sustained, longitudinal research on patient outcomes of the carve-out process.
- Encourage the Massachusetts Bureau of Managed Care and Office of Patient Protection to work with plans so that behavioral health care carve-outs generate validated utilization, outcome, and payment measures that can be used in ongoing assessments of carve-out functioning, and make these measures available to the general public.

RECOGNITION OF THE VALUE OF MENTAL HEALTH SERVICES

- Recognize the value of subspecialty services such as child psychiatry, difficult case consultation, and needs of the seriously mentally ill.
- Recognize costs of living and of care delivery.
- Offer a readily available, courteous claims resolution process.
- Facilitate provider network participation with the use of nationally or locally established uniform credentialing agreements.

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

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

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

Insurance Company Health Surveys

The Massachusetts Medical Society (MMS) opposes the collection of sensitive mental health information by insurance companies that is requested directly from patients. *(D)*

The MMS will take all appropriate action to prevent insurance companies' use of personal health surveys as a factor in determining provider compensation or patient coverage and eligibility. *(D)*

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

MINORITIES

Biomedical Sciences Career Project
The Massachusetts Medical Society will support and contribute to programs such as the Biomedical Sciences Career Project to expand educational opportunities in medicine and the biomedical sciences for underrepresented minorities. The Massachusetts Medical Society will work with Massachusetts medical schools to promote recruitment of underrepresented minorities into medicine.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

Medical Interpreters
That the MMS work with other interested parties, if available, in measuring, evaluating, and improving the quality of medical care provided to patients with significant language and/or cultural barriers. *(D)*

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

The Massachusetts Medical Society (MMS) recognizes the importance of the language barriers and cultural sensitivity and support the use of interpreter services when legally required or otherwise appropriate, whether for reasons of language, culture, or physical disability. *(HP)*

The MMS will collaborate with health plans to provide coverage for their increased costs of interpreter services necessary for providing high-quality medical care to patients who have significant language and/or cultural barriers or physical disabilities. *(D)*

MMS House of Delegates, 12/3/05
Items 1 and 3 of 3 Reaffirmed MMS House of Delegates, 5/19/12
(Item 2 of Original: Sunset)

Minority and Immigrant Populations
The Massachusetts Medical Society (MMS) will increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. *(D)*

The MMS supports the elimination of racial and ethnic disparities in health care as an issue of high priority. *(HP)*

The MMS endorses the Mission Statement and Vision Statement of the Commission to End Health Care Disparities, which reads as follows:

Commission to End Health Care Disparities

Mission Statement:
The Commission to End Health Care Disparities, inspired by the Institute of Medicine report, *Unequal Treatment*, recognizes that health care disparities exist due to multiple factors, including race and ethnicity. We will collaborate proactively to increase awareness among physicians and health professionals; use evidence-based and other strategies; and advocate for action, including governmental, to eliminate disparities in health care and strengthen the health care system.
Vision Statement:
Aided by the work of the Commission and its member organizations, physicians, health professionals, and health systems will provide quality care to all people.
(HP)

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

The Massachusetts Medical Society, recognizing that race and ethnicity are concepts that are sensitive and difficult to define, and yet important determinants of health outcomes, supports the use of the uniform and standardized classification system of the U.S. Bureau of the Census, during the voluntary collection of race and ethnicity data.

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

The Massachusetts Medical Society adopts the following policy statement on The Provision of Health Care for Minority and Immigrant Populations:

The Massachusetts Medical Society, in its role as advocate for patients, will promote a coordinated strategy for: increasing access to medical care for minority populations; heightening awareness of cultural practices through education; and creating greater opportunities for minorities and immigrants within the medical profession, including participation in the Massachusetts Medical Society.

I. Increasing Access to Medical Care for Minority Populations

The Massachusetts Medical Society recognizes that access to medical care is the first step to ensuring quality and improved outcomes. Therefore, the Massachusetts Medical Society will continue to strive for universal access to medical care, regardless of race, ethnicity, socio-economic status or geographic location.

MMS will encourage and work with community outreach programs that address the health care needs of minority and immigrant communities. In addition, the Society will continue to develop links with community-based organizations and social service agencies to identify community-wide health problems and organize health education programs that are specifically tailored to the needs of those particular communities.

II. Heightening Awareness of Cultural Practices and Barriers through Education

The Massachusetts Medical Society should promote increased awareness and research among physicians and medical students on the ethnic and cultural differences between patients, physicians and other health care providers that can create barriers to good quality health care and research. The Massachusetts Medical Society supports the expansion of educational opportunities for medical students, residents, and physicians in the areas of cultural awareness and ethnic diversity.

III. Creating Opportunities for More Diversity within the Medical Profession

The Massachusetts Medical Society supports the expansion of educational opportunities in biomedical careers for minority and immigrant populations.

The Society encourages physicians and health care organizations to employ culturally diverse staff, at all levels, in order to address the needs of the community.

MMS House of Delegates, 5/16/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11
(Item III: Amended and Reaffirmed MMS House of Delegates, 5/21/11)
(Item 5 of Original 5, Sunset: 5/21/11)

NURSES AND NURSING

Nursing Profession

The Massachusetts Medical Society (MMS) acknowledges the essential role of nurses in the overall care of patients.

The MMS recognizes that there is a shortage of professional bedside nursing services.

The MMS supports the efforts of the nursing profession in Massachusetts to attract well-qualified candidates for nursing education programs.

The MMS urges hospitals and other health care settings to provide clinical education opportunities for nursing students.

The MMS urges physicians to cooperate and participate in in-service training programs for nurses.

The MMS urges hospitals, when assigning nurses, to prominently consider training and expertise as well as appropriate nurse to patient ratios.

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

PHYSICIAN PAYMENT

Capitation
The Massachusetts Medical Society (MMS) supports physicians' right to contract directly with payers to obtain payment for services. *(HP)*

The MMS opposes the imposition of capitation on physicians and groups that are not ready by insisting that the decision to accept capitation be voluntary. *(HP)*

The MMS opposes any activity on the part of government or insurance companies that decreases payments to physicians as incentives to accept capitation. *(HP)*

The MMS will use its resources to oppose elimination of fee-for-service medicine. *(D)*

The MMS will publicly promote the high quality of medical care in Massachusetts and educate the public and our public officials that many of the benefits of high-quality health care measures, such as prevention, screening, chronic disease management, electronic health records, and wellness programs, improve care and produce value. *(D)*

MMS House of Delegates, 12/5/09
(Reaffirmed for One Year Pending New Policy Submission at A-17)

The MMS opposes the implementation of a statewide universal compensation system of global payment. *(D)*

MMS House of Delegates, 12/5/09
(Reaffirmed for One Year Pending New Policy Submission at A-17)

Claims Processing
The MMS will develop and implement a plan, which may include legislation or regulatory action that enables physician practices (to include an IPA, PHO, health care network, or health care system) that participate in any quality risk contract with a health insurance plan be able to access a report of initial claims for services from the health insurance plan in a timely fashion. *(D)*

An initial claims report from the health insurance plan for services will be made immediately available to the physician entities involved when the claims requests are received by the health insurance plans. *(D)*

MMS House of Delegates, 5/14/10

That in the event that the MMS has evidence that there is a major discrepancy among payers or unreasonable delay in payment, the Medical Society will take appropriate action as permitted by law to correct this problem.

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
(Item 1 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/2/14

CPT Codes
The Massachusetts Medical Society will encourage the American Medical Association to create a new CPT code for communication and transmission of data to the admitting hospitalist for timely coordination of care (via telephone, fax, e-mail, or face-to-face communication) and from the hospitalist to the outpatient doctor. *(D)*

The MMS will encourage the AMA to advocate for reasonable payment for the new handoff/admission/discharge coordination-of-care CPT code by the CMS-Medicare. *(D)*

The MMS will encourage the AMA and others to advocate for proper recognition of services of primary care physicians by hospitals and medical schools. *(D)*

MMS House of Delegates, 5/14/11

The Massachusetts Medical Society (MMS) will advocate to the American Medical Association (AMA) for increased effort to support the concept that third-party payers should provide more equitable reimbursement for physicians' services, and that these efforts will be directed to achieve equitable compensation for all physicians. *(D)*

The MMS will continue to advocate for reimbursement for all physicians' services as reflected in the AMA's Current Procedural Terminology codebook. *(D)*

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

Creation of Physicians' Associations (Guilds or [non-striking] Union-like Associations)
The MMS shall increase advocacy on behalf of individual members.

The MMS shall educate members regarding alternative practice arrangements.

The MMS supports changes in federal law to permit independent contractor physicians to engage in collective bargaining.

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12

Physician-Led Team-Based Health Care
The Massachusetts Medical Society adopts the following adapted from American Medical Association policies:

> The MMS will encourage independent physician practices and small group practices to consider opportunities to form health care teams such as through independent practice associations, virtual networks, or other networks of independent providers. *(D)*
>
> The MMS will encourage public and private health insurers to develop and offer a variety of value-based contracting options so that physician practices can select payment models that best suit their delivery of care. *(D)*
>
> The MMS will encourage the Centers for Medicare and Medicaid Services to ensure that Medicare Alternative Payment Models do not require physicians to assume responsibility for costs that they cannot control. *(D)*
>
> The MMS will continue to actively advocate to the Centers for Medicare and Medicaid Services that physicians in all specialties and modes of practice must have at least one Medicare Alternative Payment Model in which they can feasibly participate. *(D)*
>
> The MMS will advocate to the Centers for Medicare and Medicaid Services that any review process of alternative payment models proposed by stakeholders be completed in a timely manner include an administratively simple appeals process and access to an ombudsman. *(D)*

MMS House of Delegates, 5/7/16

Recoupment Limitations
The MMS will immediately draft legislation that establishes a time limit for recoupment of payments which is equal to the time limit that is established by each payer for the submission of claims, only excepting demonstrably fraudulent or criminal activities and actively seek to have this legislation filed in the 2011–2012 state legislative session. *(D)*

MMS House of Delegates, 5/21/11

When notified of an overpayment on a claim, the insurance company cannot perform automatic recoupments. *(HP)*

Physicians, when notified, will have 35 days to contest the overpayment before payment is due. *(HP)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Item 1 and bullets 1 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16

Resource Based Relative Value Scale (RBRVS)
The Massachusetts Medical Society urges the American Medical Association to lobby aggressively the Health Care Financing Administration [CMS] that any federal statutory or regulatory mandate(s) implemented after January 1, 1992 simultaneously include the practice costs associated with the mandate(s) in the practice cost component of the Medicare RBRVS payment system. Said increase(s) in the practice cost component shall not be taken into consideration in determining compliance with budget neutrality; that the Massachusetts Medical Society urge the American Medical Association and its federation members to lobby aggressively the Health Care Financing Administration [CMS] and state officials that any federal or state mandate(s) implemented after January 1, 1992 simultaneously include the practice costs associated with the mandate(s) in Medicaid rates of payment to physicians. Said increase(s) in rates shall not be taken into consideration in determining compliance with budget neutrality; that the Massachusetts Medical Society encourage its members and sister organizations to urge their members to communicate

their concerns about timely recoupment of practice cost and other health care cost increases associated with federal mandates to the President, the Health Care Financing Administration [CMS] and the Congress.

MMS Council, 5/14/93
Reaffirmed MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14

Third Party Insurers

The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or directives for all insurance carriers, including Medicaid and Medicare, to pay for mandated services required by law or regulation. *(D)*

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

The Massachusetts Medical Society will advocate to payers and support legislation to require payment to physicians and other health care providers for services rendered if — at the time of the patient's visit — the provider verified coverage through the insurer's available eligibility inquiry system(s), regardless of: future retroactive eligibility changes by the employer or patient, or errors in the insurer's eligibility system. *(D)*

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

The Massachusetts Medical Society (MMS) will continue to communicate to the health plans that a uniform minimum time allowance for the submission and resubmission of nonfederal claims would enhance physicians' ability to meet administrative requirements. *(D)*

The MMS will advocate for a uniform minimum time allowance for nonfederal claims of at least 90 days for:

(a) the initial submission of claims;
(b) the resubmission or initial submission of claims to another health plan, in which 90 days would be calculated from the date of the first insurer's remittance advice;
(c) the submission of additional information, in which 90 days would be calculated from the date the physician receives a communication from the health plan requesting additional information; and
(d) the submission of a claim to a new insurer after retroactive notification of loss of eligibility due to insurer change. *(D)*

That the MMS monitor health plans' adherence to their filing-limit policies and communicate noncompliance to the appropriate parties. *(D)*

That the MMS continue to utilize administrative and legislative activities to promote the establishment of equitable physician recoupment policies at health plans. *(D)*

MMS House of Delegates, 11/9/02
Amended and Reaffirmed MMS House of Delegates, 11/8/03
Reaffirmed and Item 1 Amended and Reaffirmed MMS House of Delegates, 5/14/10

The Massachusetts Medical Society (MMS) will advocate for laws, regulations, or directives for all insurance carriers, including Medicaid and Medicare, to pay for mandated services required by law or regulation. *(D)*

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

The Massachusetts Medical Society will work with the state legislature and the Massachusetts Division of Insurance to ensure that if a claim is defective, then a third party payer will notify providers within fifteen days of receipt of the claim as to the nature of the defect.

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

PHYSICIANS

Collegiality
The Massachusetts Medical Society (MMS) will promote activities for improving collegiality among physicians.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Definition of "Disruptive Physician Behavior"
The MMS will continue to promote measures to protect physicians from being inaccurately or unfairly labeled as a disruptive physician. *(D)*

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

Gender Parity
The Massachusetts Medical Society endorses the American Medical Association's policy, "Gender Disparities in Physician Income and Advancement" that reads as follows:

Gender Disparities in Physician Income and Advancement

1. That our American Medical Association encourage medical associations and other relevant organizations to study gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics, and develop programs to address disparities where they exist;
2. That our AMA support physicians in making informed decisions on work-life balance issues through the continued development of informational resources on issues such as part-time work options, job sharing, flexible scheduling, reentry, and contract negotiations;
3. That our AMA urge medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession;
4. That our AMA collect and publicize information on best practices in academic medicine and non academic medicine that foster gender parity in the profession; and
5. That our AMA provide training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit.

(HP)
The MMS will advocate and raise awareness for gender parity, equal pay, and advancement as a fundamental professional standard to ensure equal opportunity within the medical profession in Massachusetts. *(D)*

MMS House of Delegates, 5/21/11

JC Standards
The Massachusetts Medical Society will:

- Communicate to the Joint Commission on Accreditation of Healthcare Organizations (JC) the concern regarding the unintended consequences of JCAHO's standards, and methods of communicating those standards to physicians
- Advocate with the JC for direct communication to physicians organizations about standards to be adopted or modified, with at least six months available for open commentary and feedback
- Advocate that this communication be timely and that it occur in print media as well as through e-mail
- Advocate that JC accreditation standards be made available to any licensed physician without hindrance
- Advocate that the JC establish a process for any physician to provide feedback about JCAHO programs that affect that physician's practice

(D)

MMS House of Delegates, 5/12/06
Items 1-5 of Original 6: Reaffirmed MMS House of Delegates, 5/11/13
(Item 6 of Original 6 Bullets: Sunset)

Peer Review
The MMS continues to recognize the value of a peer review system for protection of patient care and will continue to monitor the incidence, prevalence, and impact of medical peer review misuse on the physician workforce in Massachusetts. *(D)*

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

The MMS will publicize and promote its policies regarding standards of care, including ethical professional behavior, to the Massachusetts Board of Registration in Medicine and/or any other entity engaged in the evaluation of such professional standards. *(D)*

The MMS will publicize and promote its Peer Review Consultant Referral List to assist the Board of Registration in Medicine as well as any other entity engaged in the conduct of medical peer review in order to help obtain just resolution of all questions related to standards of care given and ethical behavior practiced by physicians. *(D)*

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

The MMS reaffirms that, as a condition of membership in the MMS, members shall be subject to the grievance review process as outlined in Chapter XII of the current MMS Bylaws for the following apparent or alleged offenses:

(a) Violation of the MMS Code of Ethics
(b) Violation of the AMA Principles of Medical Ethics
(c) Presenting false certificates or false statements of character or of educational attainments
(d) Engaging in conduct unbecoming a physician *(HP)*

The MMS reaffirms that the MMS Committee on Ethics, Grievances, and Professional Standards, in keeping with the requirements of Chapter XII of the current MMS Bylaws, shall investigate grievances submitted by physicians against physician members and may consult the registry of impartial experts as a resource to render its decision. Should the accused member fail to appear for a conference, the committee may consider the matter on the basis of the information before it. The Committee on Ethics, Grievances, and Professional Standards shall have the authority to refer a complaint to the Massachusetts BRM if the member involved in the complaint repeatedly fails without good cause to provide information requested by the committee or repeatedly fails to appear for a conference requested by the committee without good cause. *(HP)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 1, 2, and 5 of Original: Sunset)

Physician Call

The Massachusetts Medical Society will create a task force on physician on-call compensation that will collect, aggregate, and report data on:

1) The state of compensated versus uncompensated on-call duties
2) Which specialties are being compensated for covering calls
3) The range of call-coverage compensation

The task force should further recommend model changes to hospital bylaws on emergency department coverage and compensation that are legally and ethically sound. (D)

MMS House of Delegates, 5/6/14

The Massachusetts Medical Society adopts the following principles:

MMS On-Call Principles:

The MMS On-Call Principles apply to all physicians. These principles are separate and distinct from the formal regulations governing resident work hours that must be followed by hospitals for residency program accreditation by the Accreditation Council for Graduate Medical Education (ACGME).

1. The MMS opposes government regulation of physician work hours.
2. The MMS opposes uniform limits or any other consecutive time constraints, as these can compromise patient care and limit flexibility of scheduling within individual physician practices. Furthermore, the broad diversity of specialty practices indicates that a uniform or standardized approach to regulation of physician work hours would not be appropriate.
3. Physicians have an ethical duty to their patients and profession to provide safe, compassionate, quality medical care. These duties depend on a safe and healthy working environment for all physicians. To this end, clinical responsibilities must be organized in such a way as to prevent excessive patient care responsibilities, inappropriate intensity of service or case mix, and excessive length and frequency of call contributing to excessive fatigue and sleep deprivation.
4. The individual physician can most appropriately determine whether the clinical schedule allows the physician to meet her/his ethical obligations to the patient.

5. There should be adequate backup if sudden, unexpected patient care needs create fatigue sufficient to jeopardize patient care during or following the on-call period. Institutions and other practice organizations should ensure that such backup is available if required. No institution or call system should require a physician to provide clinical care when the physician believes that she/he will not be able to meet her/his ethical obligations to the patient.
6. Health care delivery systems must have formal mechanisms specifically designed for promotion of physician well-being and prevention of impairment.
7. As there are different duties defined by each specialty, guidelines for work-hour responsibilities should be made in consultation with each physician, given that responsibilities vary by setting, region, and specialty. In addition, what constitutes excessive fatigue and sleep deprivation will vary by physician.
8. Each specialty department should determine who among its members are required to serve on-call for the emergency department, subject to appropriate compensation to be determined at the local level. In making the determination for who is required to serve on-call, the specialty department may exempt from call service members above a certain age, or with a certain number of years service to the medical staff, or those serving in medical staff leadership positions. Other individual exemptions, for hardship, temporary disability, or other reasons may be granted by the chair on a case-by-case basis.
9. Physicians and hospitals should work collaboratively to develop solutions to on-call needs for emergency departments; adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage; the organization and function of on-call services should be determined through hospital policy and medical staff by-laws; and include methods for monitoring and assuring appropriate on-call performance.
10. It is in the best interests of patients when physicians practice in a fair, equitable, safe, healthy, and supportive environment.

(HP)

The MMS will explore working with the Massachusetts Hospital Association (MHA) to develop systems for on-call coverage. *(D)*

The MMS will explore other solutions to on-call coverage, including the development of a “surgicalist” or “acute care surgery” specialty, locum tenens, and assistance from larger medical centers for smaller hospitals. *(D)*

The MMS will advocate for malpractice reform to specifically address increased liability associated with emergency call coverage. *(D)*

MMS House of Delegates, 5/14/10

The Massachusetts Medical Society will explore modifying its model Medical Staff Bylaws, as necessary, to address emergency department call coverage policies. *(D)*

The MMS will explore ways in which to address the safety and equitability of specialty emergency department on call coverage by all institutions, with a special emphasis on underserved communities. *(D)*

MMS House of Delegates, 12/5/09
(Reaffirmed for One Year Pending New Policy Submission at A-17)

The MMS will work with all appropriate parties to develop broad guidelines or principles for ensuring the balance between necessitating physician on-call services and meeting the needs of the patient population that account for the following:

- On-call services vary by setting, region, and specialty, and therefore, cannot be so specific that they would explicitly dictate a physician’s practice.
- Any guidelines developed should provide the physician with the flexibility to determine the direction of his or her career.
- Any guideline should accommodate and balance appropriate time off in determining physician responsibility. *(D)*

MMS House of Delegates, 5/08/09
(Reaffirmed for One Year Pending New Policy Submission at A-17)

Practice Valuation in Divorce

The MMS will advocate for physician practice valuation in divorce be done at Fair Market Value, rather than Fair Value, as is consistent with federal statutes governing other transactions involving physician practices. *(D)*

MMS House of Delegates, 5/19/13

Practice Viability
The Massachusetts Medical Society will create, maintain, and make accessible to medical students, residents and fellows, and physicians, resources to enhance satisfaction and practice sustainability for physicians in private practice. *(D)*

The MMS will recommend to the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education, that they encourage medical schools and residency programs to present physicians in training with information regarding private practice as a viable option. *(D)*

MMS House of Delegates, 5/6/14

The Massachusetts Medical Society (MMS) will continue to explore ways to help recruit and retain primary care physicians into the Commonwealth of Massachusetts. *(D)*

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

The Massachusetts Medical Society will work with the Commonwealth of Massachusetts to create incentives to encourage more physicians to continue practicing in Massachusetts. *(D)*

The MMS will work with all health care stakeholders to encourage active development of re-entry options for physicians who have taken time out from practice. *(D)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

The Massachusetts Medical Society will monitor the impact of hospital systems' expansion on community hospitals and physician practices and the ultimate cost and quality of health care. *(D)*

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

The Massachusetts Medical Society shall continue its advocacy and outreach campaign to educate the public, purchasers, public officials and opinion leaders on the challenges facing physician practices; to express the need to cover rising costs in order to maintain practice viability; to secure proper allocation of premium to ensure patient care; and to create awareness about the difficulty recruiting and retaining physicians in Massachusetts.

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

Principles on Medical Professional Review of Physicians
The Massachusetts Medical Society adopts the following amended Principles #2, #10, and #27 policy and principles on *Medical Professional Review of Physicians within Health Insurance Companies and Medical Professional Review of Physicians within Health Care Facilities.*

These principles are separate from the model principles that apply to medical peer review of physicians for health care facilities. The following principles include an independent appeal and review process for disputed peer review outcomes by a health insurance company.

Massachusetts Medical Society Policy on Medical Professional Review of Physicians within Health Insurance Companies

Introduction:
Activities conducted by health insurance companies to evaluate the performance of physicians may or may not constitute "peer review" or "professional review activity" under Massachusetts or federal law, depending on whether or not such activities fall within the requisite statutory definitions. The MMS believes that all such activities, however, should follow a fair, evidence-based, ethical, and coherent process, and has therefore adopted the following Model Principles for Professional Review of Physicians within Health Insurance Companies as guidance for such activities as may be applicable to their setting.

The following recommendations are made based on the above considerations in order to enhance:

- Quality improvement
- Credibility in the process of medical professional/peer review of physicians
- Fairness and due process
- Patient access — by not inappropriately terminating, removing or sanctioning physicians
- System approaches to patient safety and quality of care.

Model Principles for Medical Professional Review of Physicians within Health Insurance Companies

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event should include not only prevent factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician on a confidential basis. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the "incident" and explore alternate courses of action, all on a confidential basis.
4. The process should be mindful of, and attuned to, prevention; and the outcome should include recommendations, if appropriate, for individual remediation.
5. Triggers that initiate a medical professional review within a health plan should be valid, transparent and available to all credentialed, participating provider or contracted physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process. Such cases should be referred to Physician Health Services, Inc., or another appropriate physician health or wellness program.
7. At a minimum, the standards set by the Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity for "professional review bodies" should be followed if a disciplinary process is engaged during medical professional review. These standards are the most elementary safeguards of due process for medical professional review activities.

Section 11112 Standards for professional review actions
"a. In general…professional review action must be taken–
(1) in the reasonable belief that the action was in the furtherance of quality health care,
(2) after a reasonable effort to obtain the facts of the matter,
(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."

"Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):
(1) Notice of proposed action
The physician has been given notice stating –
(A) (i) that a professional review action has been proposed to be taken against a physician
(ii) reasons for the proposed action
(B) (i) that the physician has the right to request a hearing on the proposed action
(ii) any time limit (of not less than 30 days) within which to request such a hearing, and
(C) a summary of the rights in the hearing under paragraph (3).
(2) Notice of hearing–If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –
(A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.
(3) Conduct of hearing and notice–If a hearing is requested on a timely basis under paragraph (1)(B) –
(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –
(i) before an arbitrator mutually acceptable to the physician and the health care entity,
(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
(C) in the hearing the physician involved has the right –
(i) to representation by an attorney or other person of the physician's choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right–
(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision."

In addition, the notice of hearing should contain a summary of the allegations and of the episodes of care under evaluation.

8. Summary termination of credentials or of participating provider contract or status (or, if applicable, suspension or restriction of clinical privileges) should only be used to prevent "imminent danger to the health of any individual." Such summary actions should be followed by adequate notice and hearing procedures prior to becoming final.
9. All parties involved in the medical professional review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the medical professional review process should be available to the subject physician to the fullest extent legally permissible.
10. A medical professional review panel or peer review committee, engaged in a formal medical professional/peer review, corrective action or disciplinary proceeding, should not include direct economic competitors of the subject physician or those for whom there may be bias or lack or objectivity vis-à-vis the subject physician, and should, whenever feasible, include a fair representation of specialists/subspecialists from the subject physician's specialty/subspecialty from among credentialed, participating provider or contracted physicians within the health plan. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to the commencement of the proceedings. Such challenge would be part of the procedure specified in the health insurance company bylaws outside of peer review protections and not a part of the actual conduct of peer review and shall not be protected by peer review statuatory protections.

11. Health plans should employ mechanisms to rotate service on their medical professional review panels or peer review committees among their credentialed, participating provider or contracted physicians.
12. Membership on the medical professional panel or peer review committee should be open to all credentialed, participating provider or contracted physicians in the health plan and not be restricted to one or more groups such as employed or salaried physicians only. The committee should include more than just medical directors, medical officers or other administrative officers of the health plan.
13. Only physicians are peers of the subject physician, and only physicians should be voting members of committees conducting medical professional review of physicians.
14. Whenever a medical professional review panel or peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the health plan while excluding direct economic competitors, or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution (e.g., medical specialty society) authorized to conduct peer review of physicians should be appointed in accordance with the health plan's bylaws if such actions fall within statutory medical professional/peer review protections.
15. Physicians serving on the medical professional review panel or peer review committee should receive information and, where available, training, in the elements and essentials of medical professional/peer review.
16. The health plan should ensure that the physicians serving on any medical professional review panel or peer review committee are provided with appropriate indemnification and insurance for medical professional/peer review acts taken in good faith. The health plan should also provide assistance to the panel or committee in abiding by the requirements of HCQIA to be eligible for federal immunity if applicable.
17. The medical professional review panel or peer review committee of a health plan should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination on matters of quality care or professional competency. When the matter before the medical professional review panel or peer review committee involves professional conduct, such as an allegation of disruptive behavior, the medical professional review panel or peer review committee should be guided by

applicable professional ethical principles (e.g., MMS Code of Ethics, AMA Principles of Medical Ethics, relevant specialty society ethical codes). Those guidelines, standards, practices and principles should be made available in a timely manner to the subject physician before any hearing on the matter.

18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.
19. Wherever feasible, structured assessment instruments and, if available, multiple reviewers should be used to increase reliability.
20. Where feasible, statistical analysis to compare with peers' performance should be used with appropriate case mix adjustment.
21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.
22. All the pertinent information obtained by the medical professional review panel or peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.
23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.
24. Any conclusion reached or action recommended or taken should be based upon the information presented to the medical professional review panel or peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.
25. If the conclusion reached is that improvement is necessary, any action recommended by a health plan should include, as an important focus, steps for remediation, as needed, for the subject physician.
26. The findings, recommendations and actions of the medical professional review panel or peer review committee of a health plan should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it should address what specific remediation, if any, is recommended for the physician (whenever feasible, in terms that permit measurement and validation of remediation, when completed).
27. A process should be available to appeal any disciplinary finding of a health plan following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the health plan, should be made available to the subject physician within statutory medical professional/peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.
28. In all instances of medical professional review activities conducted within health insurance companies, the applicable processes and procedures should be clearly stated, with specific detail, in health plan provider manuals or written policies, of uniform application, made available in advance to the subject physician. Such processes and procedures should contain the particular due process, hearing and appeals rights available to the subject physician, and, to the extent that medical professional review or peer review privilege, confidentiality and immunity legal protections are available to such medical professional review activities, such processes and procedures should conform to the requirements of federal and state law. In conformity with Principle No. 12, to avoid or at least mitigate conflicts of interest, or the perception thereof, the medical professional review panels or peer review committees of health insurance companies should include as members with full participation and voting rights physicians who are not employees or contractors (other than contracting as a participating provider) of the health insurer.
29. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment. *(MMS Council, 5/17/91; Reaffirmed, House of Delegates, May 7, 1999)*
30. These Model Principles for Medical Professional Review of Physicians within Health Insurance Companies are intended to apply to all medical professional review activities conducted by health insurance companies of their credentialed, participating provider or contracted physicians, however designated: e.g., professional review, peer review, credentialing appeals, corrective actions or otherwise.

(HP)
(MMS House of Delegates, 5/08/09)

1. The Massachusetts Medical Society amends its existing Model Principles for Incident-Based Peer Review for Health Care Facilities to include an independent appeal and review process for disputed peer review outcomes by

a hospital and to update the principles to account for changes in regulations and standards developed since the principles were created in 2003 as to read as follows:

Massachusetts Medical Society Policy
Model Principles for Medical Peer Review of Physicians for Health Care Facilities

2. The following recommendations are made based on the above considerations in order to enhance:
   • Quality improvement
   • Credibility in the process of medical peer review of physicians for health care facilities
   • Fairness and due process
   • Patient access — by not inappropriately removing or sanctioning physicians
   • System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care facility must not only include prevent factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the "incident" and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.
7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.
   Section 1112 Standards for professional review actions
   "a. In general…professional review action must be taken–
   (1) in the reasonable belief that the action was in the furtherance of quality health care,
   (2) after a reasonable effort to obtain the facts of the matter,
   (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
   (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."

   "Adequate notice and hearing–A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):
   (1) Notice of proposed action
      The physician has been given notice stating –
      (A) (i) that a professional review action has been proposed to be taken against a physician
         (ii) reasons for the proposed action
      (B) (i) that the physician has the right to request a hearing on the proposed action
         (ii) any time limit (of not less than 30 days) within which to request such a hearing, and
      (C) a summary of the rights in the hearing under paragraph (3).
   (2) Notice of hearing–If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –
      (A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
      (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.
   (3) Conduct of hearing and notice–If a hearing is requested on a timely basis under paragraph (1)(B) –
      (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –

(i) before an arbitrator mutually acceptable to the physician and the health care entity,
(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right –
(i) to representation by an attorney or other person of the physician's choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right
(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision."

In addition, the notice of hearing should contain a summary of the allegations and the episodes of care under evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to prevent "imminent danger to the health of any individual." Such summary actions must be followed by adequate notice and hearing procedures prior to becoming final.
9. All parties involved in the peer review process must preserve the confidentiality of all records, information and proceedings. However, all of the facts obtained for and in the peer review process shall be available to the subject physician to the fullest extent legally permissible.
10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include direct economic competitors of the subject physician or those for whom there may be bias or lack of objectivity vis-à-vis the subject physician and should include a fair representation of specialists/subspecialists from the subject physician's specialty/subspecialty whenever feasible. The subject physician shall have the right to challenge, in writing, proposed peer review committee participants for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures specified in the health care facility bylaws, outside of peer review protections and not part of the actual conduct of peer review and shall not be protected by peer review statutory protections.
11. Physicians should rotate service on the peer review committee (round robin).
12. Membership on the peer review committee must be open to all physicians on the medical staff and not be restricted to one or more groups such as those practicing exclusively at a given institution, salaried physicians only or faculty physicians only.
13. Only physicians should be voting members of committees conducting medical peer review of physicians.
14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject physician cannot effectively be constituted with physicians from within the institution while excluding direct economic competitors or at the request of the subject physician, qualified external consultants or an external peer review panel through another appropriate institution authorized to conduct peer review of physicians should be appointed in accordance with the medical staff bylaws and medical peer review protection statutes.
15. Physicians serving on the peer review committee should receive information and where available, training, in the elements and essentials of medical peer review.
16. The hospital or the organization on whose behalf the peer review is done must ensure that the physicians serving on any peer review committee are provided with appropriate indemnification and insurance for peer review acts taken in good faith. The organization must also provide assistance to the committee in abiding by the requirements of HCQIA to be eligible for federal immunity.
17. The peer review committee of a health care facility should be guided by generally accepted clinical guidelines and established standards and practices, when available, in making their determination. When the matter before the peer review committee involves professional conduct such as an allegation of disruptive behavior, the peer review committee should be guided by applicable professional ethical principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society ethical codes).Those guidelines, standards and practices must be made available in a timely manner to the subject physician before any hearing on the matter.
18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible.

19. Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase reliability.
20. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustment.
21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or appeal.
22. All the pertinent information obtained by the peer review committee regarding the subject matter should be made available to the subject physician to the fullest extent legally permissible in a timely manner before the hearing.
23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.
24. Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias and rumor should be given no credence and should be carefully excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.
25. If the conclusion reached is that improvement is necessary, any action recommended by a health care facility should include, as an important focus, steps for remediation, as needed, for the subject physician and for the system.
26. The findings, recommendations and actions of the peer review committee of a health care facility should not be vague or stated in general terms, but should clearly and specifically state in writing the nature of the physician's act or omission, how it deviated from the standard of care or ethical principle, what the standard or ethical principle is and its source, and what specific step the physician could have taken or not taken to meet the standard of care or ethical principle. Where applicable, it must address what specific remediation, if any, is recommended for the physician and what, if any, for the system (whenever feasible, in terms that permit measurement and validation of remediation, when completed).
27. A process should be available to appeal any disciplinary finding of a health care facility following the hearing, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician. An appeals process before a disinterested third party, not connected to the medical staff or the hospital, should be made available to the subject physician within statutory peer review protections. If the original action was part of a peer-review protected process, the appeal should be part of the peer-review protected process as well.
(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)
28. The Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment.
(MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)

(HP)

MMS House of Delegates, 11/08/03
**Health Care Facilities Principles Amended and Reaffirmed MMS House of Delegates, 5/08/09*
(Items 2, 10, of "within Health Insurance Companies and Items 2, 10, and
27 of "for Health Care Facilities): Amended and Reaffirmed MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)

The Massachusetts Medical Society recognizes that when a physician performs a medical peer review function he/she should render the same opinions that would pertain if he/she were the treating physician with responsibility to provide appropriate patient care. These opinions should not be rendered solely on the basis of cost containment.

MMS Council, 5/17/91
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Professional Responsibility
The Massachusetts Medical Society adopts the Declaration of Professional Responsibility: Medicine's Social Contract with Humanity, which reads as follows:

DECLARATION OF PROFESSIONAL RESPONSIBILITY:
MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble
Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and

genetics, while promising great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly, and at times heroically. Today, our profession must affirm its historical commitment to combat natural and man-made assaults on the health and well-being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration
We, the members of the world community of physicians, solemnly commit ourselves to:

I. Respect for human life and the dignity of every individual.

II. Refrain from supporting of committing crimes against humanity and condemn all such acts.

III. Treat the sick and injured with competence and compassion and without prejudice.

IV. Apply our knowledge and skills when needed, though doing so may put us at risk.

V. Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.

VI. Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.

VII. Educate the public and polity about present and future threats to the health of humanity.

VIII. Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.

IX. Teach and mentor those who follow us for they are the future of our caring profession.

We make these promises solemnly, freely, and upon our personal and professional honor.
(HP)

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16

Workforce
The Massachusetts Medical Society (MMS) will continue to monitor physician workforce issues through primary and secondary research, including working with health care leaders, as appropriate.

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Items 2 and 3 of Original: Sunset)

The Massachusetts Medical Society (MMS) will continue to monitor physician workforce issues through primary and secondary research, including additional relevant measures not explored in the current workforce study. *(D)*

The MMS will develop advocacy efforts to increase public, legislative, and health plan awareness of the impending shortage in physician staffing and its impact on access to care. *(D)*

The MMS will focus further analysis on evaluating the effects of non-patient care activity, such as research, teaching, and biotechnology, on the practicing physician workforce. *(D)*

The MMS will look for collaborative opportunities with physician specialty societies, health care delivery systems, and other appropriate health care organizations to study and advance initiatives related to the physician workforce and patient access to care. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Amended and Reaffirmed MMS House of Delegates, 5/7/16

MMS will advocate, as soon as is fiscally prudent, for fully funding efforts aimed at encouraging the entry and retention of more primary care physicians in the Commonwealth, such as programs to address the high cost of living in Massachusetts and various other incentives for primary care physicians.

MMS House of Delegates, 5/14/10

PREAUTHORIZATIONS

Office Practice Expenses

The MMS will sponsor legislation requiring insurance companies doing business in Massachusetts to reimburse reasonable physician office practice expenses related to physician processing of prior authorizations for medications and procedures which require a medical decision/review by a physician or other licensed health professionals under his/her supervision and/or liability coverage. *(D)*

MMS House of Delegates, 5/14/10

Preauthorizations

The MMS will advocate for the enforcement of current legislation stating that all prior authorization requests made to insurers subject to state insurance law will be deemed approved if the third-party payer does not respond within two (2) business days. *(D)*

The MMS will advocate for legislation that at the time of a medication prior authorization denial, the pharmacy benefits manager must provide the prescriber with a list of appropriate preferred alternative medications. (D)

The MMS will advocate for legislation that in the event of a rejection of a prior authorization request made to insurers subject to state insurance law, the insurance company will have two (2) business days to respond to an appropriately filed appeal and that the medical professional reviewing the appeal must have the authority to overturn the initial denial. *(D)*

The MMS will advocate for and pursue with our legislators a mandate requiring that insurers who choose to contract in the state must similarly comply with an electronic pre-authorization process, making it necessary for the pre-authorization process to be readily available to all physicians in the Commonwealth, to work seamlessly on EMR/media, for medications, diagnostic imaging, and medical services in the same manner that paper submission is accepted. *(D)*

MMS House of Delegates, 5/7/16

The process of electronic pre-authorization should be one that is immediate and accessible in real-time, with approval or denial at the point of contact. *(HP)*

It should be the responsibility of the insurer to provide transparency and full disclosure of formulary medications, acceptable alternatives, covered products and services, co-pays, and restrictions in electronic format to facilitate a less costly, more patient-centered, more expedient, and more satisfying method of pre-authorization. *(HP)*

The MMS will review and revise as necessary its Principles for the Use of Prior Authorization Programs with specific attention paid to the electronic pre-authorization process. *(D)*

The MMS will advocate for requiring insurers to make meaningful payments for time spent by physicians and staff for each communication needed to obtain prior authorizations for approval for services. *(D)*

Electronic pre-authorization not be the sole method for pre-authorization submission. Alternate methods such as fax, telephone, and paper should be allowed. *(HP)*

MMS House of Delegates, 12/7/13

The MMS will:
… attempt to identify legislative, regulatory, and third-party requirements and strategies that are most burdensome *(D)*

MMS House of Delegates, 12/2/12
(Item 1 of Original, Sunset)

The MMS will foster, via regulatory or legislative avenues, elimination of prior authorization requirements for medication approved by the FDA for the specific indication requested and are comparatively cost-effective to alternatives. *(D)*

That the MMS direct the American Medical Association to collaborate with the Centers for Medicare and Medicaid Services in the creation of a CPT code or an equivalent mechanism for professional preauthorization time and related office expenses. *(D)*

That the MMS encourage and facilitate provider reporting of undue delays in accessing the preauthorization process, obtuse denial explanations and undue delays in ultimately approved requests to the Division of Insurance (DOI); and, that the MMS request the DOI to require the health plans to submit their pre-authorization performance data to the DOI them in a common format for public disclosure and share these results with MMS, payers, and other appropriate entities for a collaborative discussion. when known, the clinical consequences of each delay by way of a simple reporting form by whatever medium stored in a database maintained by the MMS and, in turn, periodically reported to appropriate regulatory authorities and MMS membership. *(D)*

MMS House of Delegates, 5/19/12

The MMS opposes the use of preauthorization where the medication or procedure prescribed is a common and indicated one or commonly used medication for the indication as supported by peer-reviewed medical publications. *(HP)*

Any reviewer at any level of the preauthorization process be fully identified by full name, title, and location; educational level; and contact information of supervisor. *(HP)*

Third parties should make available to the Massachusetts Medical Society meaningful, aggregate statistics in usable form in a timely fashion (e.g., broken down by specialty, medication, diagnostic test, or procedure; indication offered and reason for denial and outcomes analysis) of percentages of acceptance or denial as well as other relevant trending information. Individual medical group data should be made available upon request by each group. *(D)*

MMS House of Delegates, 5/14/11

The Massachusetts Medical Society (MMS) opposes pre-certification programs of third-party payers that interfere with the physician-patient relationship, delay medically necessary care, or impose an undue administrative burden on physicians. *(HP)*

The MMS will work with third-party payers to develop meaningful hassle-free utilization review programs that are educational in design and enhance quality of patient care. *(D)*

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

The MMS takes the position that decision-making regarding preauthorization of payment for medically necessary services and treatment is the defacto practice of medicine, and those involved in those reviews should be held liable for bad outcomes and in malpractice actions stemming from delay and/or denial of care. *(HP)*

MMS House of Delegates, 12/4/10

Principles for the Use of Prior Authorization Programs
The Massachusetts Medical Society adopts as amended the MMS policy on Preauthorizations: Principles for the Use of Prior Authorization Programs adopted at I-05 and reaffirmed at A-07 to read as follows:

Principles for the Use of Prior Authorization Programs
The Massachusetts Medical Society adopts the following Principles for the Use of Prior Authorization Programs:
These principles for the use of prior authorization programs should apply whether the program is administered by a health plan, third party vendor, or provider organization.

1. Prior authorization programs should be implemented only upon a showing of substantial variation in the targeted practice and good evidence of over utilization among those providers the proposed prior authorization program would affect. Such data should be shared with the physician community well before any action is taken regarding new prior authorization programs in order to allow for appropriate improvement.
   a. Prior authorization requirements should never apply in a medical emergency, or when a patient could be harmed by the delay caused by such programs. If care is required on an urgent basis, prior authorization requirements should be suspended.
   b. The party running a prior authorization program should actively seek input from practicing physicians in development and maintenance of the program
2. All prior authorization programs should be entirely transparent to patients and physicians. This includes the provision of:
   a. A complete list of all procedures subject to any prior authorization, including all relevant codes for providers.
   b. Comprehensive clinical criteria and algorithms, as updated based on current medical literature.
3. Prior authorization programs should be operated in a manner that avoids administrative burdens for physicians and their office staff and incremental costs to physicians, other providers, and patients. Data should be reviewed frequently, and physicians who are meeting criteria should be excluded from the program.
   Proper notice of any change in prior authorization process or criteria should be communicated in a timely fashion. When applicable, electronic methods should be used to streamline any prior authorization processes.
   a. Data collected for prior authorization programs should include a minimum number of necessary data elements.
   b. Providers should be allowed to transmit required data in a number of different ways, including telephonic, fax, U.S. Postal Service, any web-based platforms, and electronically, in a Health Insurance Portability and Accountability Act (HIPAA) compliant manner.
   c. Prior authorization programs should have adequate capacity such that there are no busy signals or delays in transmitting data.
   d. Providers should receive immediate proof of submission of prior authorization data. If applicable, this may be achieved electronically.
   e. Turnaround time for prior authorization should be less than one business day for non-urgent cases.
   f. Appeals rights for patients, families, and providers should be clearly spelled out, and appeals should be readily accessible, if applicable, electronically.
   g. Appeals should require the minimum incremental information.
   h. Patients, families, or providers should have the right to present appeals information in person at a time and place that is reasonably convenient.
   i. Providers should be paid for incremental work effort of prior authorization programs.
   j. Providers should receive timely, clear, and actionable reporting on their performance in a prior authorization program.
   k. Providers who consistently meet clinical criteria should be exempted from all elements of prior authorization programs.
   l. Documentation of a denial should be sent to the clinician to include the date and time of decision, reason for denial and physician making the denial decision. Documentation shall be made available electronically, when applicable.
4. Prior authorization programs should be conducted using up-to-date clinical criteria and appropriate clinical experts.
   a. All clinical coverage criteria should be reviewed and updated regularly with evidence-based protocols.
   b. Any denials should be issued by a licensed, board certified, actively practicing physician who regularly treats patients in a clinical setting and who would typically manage the medical condition under review. Such a physician should be available whenever a preauthorization is required.
   c. Those conducting prior authorization programs should maintain a roster of patients who have been issued denials and plans should track their subsequent care for the problem for which imaging was requested. (HP)
5. Prior authorization process should support patient point-of-contact submissions with approval or denial of said submissions available at patient point-of-contact. (HP)

MMS House of Delegates, 12/3/05
Amended and Reaffirmed MMS House of Delegates, 5/18/07
Amended and Reaffirmed MMS House of Delegates, 12/6/14

PROFESSIONAL LIABILITY

ERISA

The Massachusetts Medical Society, working through its AMA Delegation together with other interested parties, will support appropriate Federal legislative initiatives to address the issue of ERISA preemption of state tort and contract law relating to the imposition of liability on self-insured health and welfare benefit plans.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Amended and Reaffirmed MMS House of Delegates, 5/21/11

The Massachusetts Medical Society (MMS) continues its support of federal ERISA preemption repeal efforts, with priority given to repealing those provisions preempting state patient protection legislation.

The MMS continues to seek comprehensive federal legislation that reforms tort liability.

The MMS continues to seek state tort reform with regard to joint and several liability.

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

The Massachusetts Medical Society shall work with the American Medical Association state Advocacy Resource Center which has developed model state legislation to end ERISA preemption of state liability law in Massachusetts and lobby Massachusetts Congressional Representatives to support this.

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

Excess Professional Liability Insurance

In order to enhance freedom of choice in the selection of medical professional liability insurance coverage, the Massachusetts Medical Society will advocate with all health insurance plans, hospital staffs, and other pertinent health care entities that any mandatory malpractice insurance coverage limit requirement higher than the state minimum should be eliminated. *(D)*

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

The Massachusetts Medical Society endorses the availability of Excess Physicians' and Surgeons' Professional Liability Insurance, at increments above and beyond the basic limits of professional liability insurance offered by insurance carriers, for choice and elective decision by the individual insured.

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

Health Courts

The Massachusetts Medical Society endorses the need for comprehensive medical professional liability reform and support the concept of health courts as an alternative to the current system and one that is worthy of further research and demonstration projects. *(HP)*

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

Joint and Several Liability

The Massachusetts Medical Society reaffirms its legislative strategy to continue to advocate for the abolition of joint and several liability. *(HP)*

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

Medical Staff Privileges
The Massachusetts Medical Society supports a policy allowing each physician to maintain what she or he determines to be an appropriate amount of liability insurance in accordance with the state licensing authority; and the Massachusetts Medical Society opposes any requirement of medical liability insurance in excess of the minimum (as established by the Massachusetts Board of Registration in Medicine) for hospital medical staff privileges.

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

No-Fault Medical Liability Insurance
The MMS endorses the concept of no-fault medical liability programs to encourage confidential reporting of medical errors so as to improve patient safety.

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

Participation in Health Insurance Plans
The Massachusetts Medical Society supports a policy allowing each physician to maintain what she or he determines to be an appropriate amount of liability insurance in accordance with the state licensing authority for purposes of participation in health insurance plans.

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

Personal Property Exemption
The MMS will seek support from other interested groups, such as the Professional Liability Foundation, Ltd., and other professional membership organizations for efforts advocating for appropriate state and federal legislation: (1) amendment to M.G.L. c. 235 §34, which currently carves out personal property exemptions from execution in Massachusetts, and M.G.L. c. 235 §34A, governing exemption of annuities, pensions, profit sharing, or retirement plans from attachment or execution; and (2) amendment to other relevant state and federal laws governing personal property exemptions from execution, bankruptcy, and other modes of asset protection in order to protect the personal property of a medical professional up to an amount equal to the face value amount of a medical professional's liability insurance policy, insuring the damages at issue in a medical professional liability action. *(D)*

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Item1 and 2 of Original: Sunset)
Reaffirmed MMS House of Delegates, 5/7/16

Physician Expert Witnesses
The Massachusetts Medical Society (MMS) adopts the following Expert Witness Testimony Standards, applicable to all physicians who testify as expert witnesses in professional liability cases in Massachusetts:

1. The physician expert witness must hold a current, valid, nonrestricted medical license.
2. The physician expert witness must be board certified in the same specialty as the defendant physician when providing expert testimony on the standard of care provided by the defendant, or board certified in their specialty when providing any other relevant expert testimony in the case. Board certification shall be with a specialty board recognized by the American Board of Medical Specialties or the American Osteopathic Association.
3. The physician expert witness must be actively engaged in the clinical practice of medicine.
4. The physician expert witness must be aware of and comply with the American Medical Association's (AMA) policies on Medical Testimony, False Testimony, Peer Review of Medical Expert Witness Testimony, Expert Witness Testimony, AMA-ABA Statement on Interprofessional Relations for Physicians and Attorneys, and other applicable expert witness testimony standards, guidelines, principles, and codes of ethics established by the American Medical Association.
5. The physician expert witness must acknowledge and comply with expert witness testimony standards, guidelines, principles, and codes of ethics established by the national specialty society for the testifying physician's specialty, and sign, if such exists, an affirmation of compliance.
6. The physician must be available at trial if rendering an opinion at the tribunal stage of the proceedings.

7. The physician expert witness must be aware that the Federation of State Medical Boards defines false, fraudulent, or deceptive testimony as unprofessional conduct, and that such testimony may be actionable by the Massachusetts Board of Registration in Medicine or any other state licensing boards with whom the physician expert witness holds licenses to practice medicine.
8. The physician expert witness must be willing to submit transcripts of depositions and courtroom testimony to independent peer review by the appropriate specialty society.

The MMS will collaborate with appropriate legal representatives, Massachusetts professional liability insurers, and the Massachusetts Board of Registration in Medicine for purposes of implementing the Expert Witness Testimony Standards in the form of MMS policy, an affirmation statement, and/or by other useful and effective means, to improve the quality of clinical evidence introduced at all stages of the litigation process. *(D)*

MMS House of Delegates, 11/6/04
Reaffirmed MMS House of Delegates, 5/21/11

The Massachusetts Medical Society will continue to advocate for legislation which requires that physician expert witnesses testifying in medical professional liability cases venued in the Commonwealth of Massachusetts must possess the following qualifications: (1) Hold a non-restricted medical license; (2) Be board certified in the same relevant specialty as the defendant physician; (3) Be actively practicing in the same specialty as the defendant physician; (4) Be available at trial if serving as the expert at the tribunal stage of the proceedings. *(D)*

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

Tort Reform

The Massachusetts Medical Society will work diligently to assure that significant changes in state payment methodology are associated with significant and meaningful professional liability reforms. *(D)*

MMS House of Delegates, 5/14/10

The Massachusetts Medical Society (MMS) will continue to advocate for:

1) elimination of the waiver on the current cap on pain and suffering;
2) elimination of joint and several liability;
3) reduction of the judgment interest rate.

The MMS will advocate for legislative reform that would require Massachusetts third party payers to adequately compensate for malpractice premium increases.

The MMS will review and study innovative and alternative forms of professional liability insurance systems, such as a no-fault insurance system and a state-sponsored risk pool system, to form the basis of possible legislative reform efforts in this area.

MMS House of Delegates, 5/31/02
Amended and Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16

That in furtherance of current MMS policy, the Society will continue to work expeditiously with appropriate stakeholders for reform of the medical professional liability tort system. *(D)*

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/8/09
(Items 1-4 of Original: Sunset)
Amended and Reaffirmed MMS House of Delegates, 5/7/16

PROFILING, TIERING, AND PHYSICIAN PERFORMANCE

Principles for Measuring and Rewarding Physician Performance
That the Massachusetts Medical Society adopt as amended the MMS Guidelines for Measuring, Reporting, and Rewarding Physician Performance adopted at A-05 and reaffirmed at A-12, and the MMS Principles on Physician Profiling adopted at I-98, and reaffirmed at A-05 and A-12, to read as follows:

Principles for Measuring and Rewarding Physician Performance

Increasingly, physicians are being judged by systematic measurement and reporting of their performance on selected quality indicators, by patient experiences with the care received, and by assessment of the appropriateness and cost-effectiveness of care. Quality improvement programs that have these goals should:

- use objective, well-validated, and clinically important measures of quality;
- ensure accurate and timely assessment of these measures;
- include physicians in both primary care and medical specialties;
- provide for timely review of reports by involved physicians prior to public release;
- ensure that reports released to the public can be easily and accurately interpreted;
- make appropriate use of risk-adjustment and statistical methods when reports aim to compare performance among clinical practices or hospitals or make clear notation that population differences make direct comparisons difficult or impossible;
- use appropriate incentives to reward superior performance and stimulate continuous improvement in the quality of care being provided;
- promote and facilitate the adoption of information technology (IT) tools including electronic health records (EHRs).

A. Goals of Performance Measurement

- The primary goal of performance measurement is to improve the quality of health care by providing physicians with meaningful information on their clinical performances. Hence, success should be measured by evidence of improvement over time in the structures, processes, and outcomes of care.
- Other important goals are to ensure physician accountability to the needs of health care consumers and accrediting and regulatory entities.
- Physician leadership is essential in developing and implementing performance measurement activities to ensure their clinical relevance and to help inform patients and the community about aspects of health care that are particularly important to physicians.
- Performance measurement must address local, as well as regional and national, priorities if local needs are to be satisfied and active physician participation is to be assured.

B. General Principles of Physician Performance Measurement

- Performance measures should be clinically relevant to the individual physician or group practice being evaluated. Markers of importance include high prevalence; significant impacts on mortality, morbidity, or costs; and high degrees of practice variation where variations have well-documented relationships to health outcomes.
- Physicians should be evaluated only with respect to patients and clinical services for whom/which they are directly responsible. Where responsibility for care is shared, the team, group practice, or hospital service should be the unit of evaluation. When attribution is uncertain, evaluation should be at the higher level of aggregation.
- Performance measures should, to the maximum extent possible, be firmly grounded in scientific evidence. Where the science base is inadequate, professional consensus may be substituted. In either case, sources of support for the measure and their validity should be fully documented and readily accessible.
- The process for selecting the range of performance measures to be included should take into account the perspectives of all involved parties including physicians, patients, health plans, provider organizations, employers, payers, and regulatory agencies.
- Quality measures must be clinically important, prospectively defined, and designed for objective and accurate measurement. They should be evidence based and directed at medical specialists as well as primary care physicians. Measures aimed at health care outcomes are preferred. Measures should adjust for case mix, distinguish between ordering and referring physicians, and other factors such as race and ethnicity if empirical evidence suggests a correlation (AMA, NQF). Measures aimed at processes of care are also important if they are closely linked to improved outcomes.

- Many quality measures used today, including Health Plan Employer Data and Information Set measures, are of marginal clinical importance. Such data should not be used in the physician peer-review process. Physician peer review should be conducted in accordance with the Society's *Model Principles For Incident-Based Peer Review for Health Care Facilities.*
- Technical barriers to accurate and timely measurement of quality need to be confronted. As sources of data, claims data have the advantages of being readily available, relatively low in cost, and inclusive of important parameters such as diagnostic and procedure codes. Shortcomings include delays in obtaining access to the data, inaccuracies, and inadequate information on the clinical needs of patients and socioeconomic indicators that may affect outcomes. Interoperability of EHRs will facilitate coordinated and complete data collection. The development of such systems should be a high priority.
- The costs of quality measurement can be considerable. Costs should be justified by tangible evidence of resulting improvements in health care quality and/or savings in the costs of health care. Measures of cost should include the added clerical burdens on physician practices or managed care organizations.
- Physicians should be intimately involved in all aspects of quality measurement in: developing quality measures, implementing and monitoring quality measurement, and reporting results to practices and the public. To these ends, physicians should work in close collaboration with payers, quality measurement organizations, and regulators.

C. Development of a Performance Measurement Program

- Development of effective performance measurement programs requires close collaboration among physicians, their health care organizations, payers, and regulatory agencies.
- Expected benefits of performance measurement should be weighed against the burden and costs for the program as a whole, and for each performance measure. The value of performance measurement will be increased by the use of standardized measures and methods, avoidance of duplication of effort, and steps to ensure the accuracy and usefulness of results.
- Ongoing performance measurement activities should receive regular external evaluations. These evaluations should focus on the choice of performance measures, data collection and analysis strategies, the accuracy of the results obtained, and the appropriateness of interpretation of results.
- Organizations that conduct performance measurement (provider organizations and vendors) should disclose fully their performance measurement objectives, policies, and methods, and make these readily accessible to both the physicians being assessed and the public.
- The burden and costs of performance measurement should be fairly allocated among those who will potentially benefit including physicians, patients, health plans, payers, employers, and regulatory agencies.

1. Characteristics of Performance Measures

- Measures should be based on data available to the clinician in the real-time clinical setting and should have clear implications for actions to improve the quality of care.
- Measures should be standardized and capable of systematic and objective measurement. Relevant data sources must be available, accurate, and reasonably complete.
- To the extent possible, measures should rely on data that are routinely collected during usual patient care.
- The burden of data collection for a measure should be reasonable.
- Measures should be updated at regular intervals to reflect changes in medical knowledge or the norms of practice.
- Measures of clinical outcomes should be risk-adjusted so that results appropriately reflect patients' severity of illness at the time of presentation or time of clinical action. Methods used for risk-adjustment should be accurate at all levels of severity of the illness.
- Measures and associated analytic methods should be clearly defined and fully disclosed to necessary parties. Measures based on un-disclosed algorithms or software are not acceptable.

2. Types of Performance Measures

- Clinical outcome measures should be clearly related to processes of care that are under the control of the physician or group practice, and can be modified to affect the outcome.
- Process measures should be clearly linked by scientific evidence to direct effects on patient outcomes. They usually relate to diagnostic and treatment decisions but may also examine access to care or compliance with care regimens.
- Patient perceptions of and satisfaction with the quality of services are important. Patients should have input into the selection of these measures.
- Patients are often the best witnesses to assess the outcomes that they experience.

- Resource use and cost measures should be supported by evidence that patient care will not be adversely affected and expectations for benchmarks should be appropriate. When efficiency measures are used, quality measures should be used in conjunction with such measures to ensure there is appropriate utilization. Decisions on the use of such measures should include individuals with no direct financial stake in the care being evaluated.
- The primary purpose of performance measurement related to resource use and costs should be to raise awareness and inform quality improvement activities. Results should not be used for punitive purposes except in cases of flagrant overuse or clear waste.

3. Data Sources

- Each data source should meet explicit standards of accuracy and completeness if valid comparisons are to be made among physicians or practices.
- The data source should be appropriate to the performance measure being examined.
- The data source should be readily available in all practices or health plans being compared.

4. Data Collection

- Data collection protocols should be explicit, as objective as possible, and limited to essential items of data.
- Data collection from medical records or by survey should be performed by persons skilled in the methodology. Ideally, these individuals should be selected and reimbursed in a manner that will optimize objectivity and minimize bias.

5. Data Analysis

- The level of analysis (individual physician, group practice, or health plan) should be appropriate to the ability of data to support meaningful analyses and the intended use of the report. Sample sizes of events or cases that are too small to support analyses at the level of the individual physician may be useful for internal quality improvement but should not be released to the public.
- Analyses should be planned and conducted by individuals who are skilled in appropriate analytic techniques.
- Analytic techniques should be appropriate to the objectives of the analysis and the database.
- Reports should emphasize important differences between the entities being compared or time trends in performance, and include clear statements about the statistical significance and clinical importance of results.
- Reports that are to be released to the public should be based on adequate sample sizes and accurate data, and meet high standards of statistical validity. Independent external audits should be performed prior to release.
- Reports that are for internal discussion/use in quality improvement activities can be based on smaller sample sizes and may not require formal statistical analysis.
- Methods of analyses should be described in sufficient detail that results can be easily understood and, if necessary, reproduced.

6. Risk-Adjustment

- Adequate risk-adjustment is essential to achieving valid comparisons among physicians, practices, or health plans on clinical outcomes and the appropriateness of decisions to perform surgical or diagnostic procedures.
- Simple adjustment for selected patient characteristics such as age, gender, and risk factors for the disease will be sufficient for certain process measures (e.g., mammographic screening for breast cancer).
- Risk-adjustment models should be carefully tested before they are used and should have demonstrated good calibration between predicted and actual outcomes at all levels of severity of illness. Generic risk-adjustment models can be used if they have been demonstrated to be valid for the particular condition and the particular type of clinical setting.
- The risk-adjustment methodology should be well-documented and open to inspection, preferably published in the peer-reviewed medical literature.

D. Distribution and Use of Performance Reports

- Physicians and physician groups being assessed should be the first to receive all reports that measure their performance. They should be given an opportunity to review and comment on reports prior to external release. In particular, physician "outliers" on a measure should be contacted to detect any unusual circumstances that

explain the result. Documented errors should be corrected, and substantive comments or explanations should be appended.

- External distribution of physician performance results should be governed by the necessary parties as defined by the responsibilities of the entity and the content of the report. Criteria for external distribution, including rules governing confidentiality of content, should be explicitly stated and agreed to by all involved parties. For example, the public should receive reports that will help them select a physician, health plan, or hospital. Regulatory agencies should only receive information specified in their credentialing standards.
- Organizations that use physician performance reports should publicly disclose the types of information they need and how this information will be used to improve the quality of health care.
- Reports intended for public release should meet higher standards of accuracy, reliability, and statistical validity than those intended for internal discussion/use only. Reports should not be released when there are too few cases to support a meaningful analysis. Appropriate risk adjustment of results is essential. Reports intended for public release should be audited by an independent entity prior to their release.
- All reports, whether for internal or external use, should be clear and unambiguous and accompanied by materials that facilitate proper interpretation. Reports should be protected from discovery during legal proceedings.
- Performance reports used for internal quality improvement should remain confidential between the physician or physician group being measured and their immediate supervisors. Such reports should be protected from disclosure by peer review regulations, whenever possible.
- Reports keyed to sentinel events should be used only for internal quality improvement unless statistically valid patterns of performance can be documented.
- Patient-specific data may, where necessary, be released to the patient's physician for use in internal quality improvement activities. Broader release of patient-specific data, however, should require explicit permission of the patient.

E. Public Reporting of Physician Performance

- The public expects and deserves valid reports on the performance of all health care providers: medical practices, managed care organizations, hospitals, nursing homes, and other services.
- Reports for public release must meet high standards for accuracy and statistical validity. Reports should not be released when there are too few cases to support a meaningful analysis. They should receive timely review by involved practices prior to release, and should be corrected for discovered errors or risks of misinterpretation. Particular attention should be given to ensure that physicians are held accountable only for care for which they are, in fact, responsible.
- Reports that compare performance of physicians or practices to each other or to benchmarks must avoid using arbitrary cutpoints that designate practices as being "superior," "above average," "average," or the like. Instead, performance should be rank-ordered according to the quality measure under consideration. Ranking should be based on clinically important and statistically significant differences.
- Reports must pay careful attention to differences in sociodemographic and socioeconomic classes and cultural divides that may affect patient attitudes toward health care and adherence to recommendations of their physicians.

F. Frequency of Performance Reports

- The frequency of reports depends on the intended purpose. If the goal is to achieve behavior change and quality improvement, frequent reinforcement by quarterly reports may be required. Annual reports are usually sufficient for comparisons among health plans or to satisfy accrediting agencies.
- The burden of data collection and other costs of performance measurement will be limiting factors both for the selection of performance measures and the frequency of reports.

G. Assessing the Quality of Patient-Physician Relationships

- Quality-measurement programs should be directed at supporting and improving patient-physician relationships. To these ends, they must reflect the vital importance of sound medical judgments as well as adherence to defined guidelines.
- Programs should protect and improve access to high-quality health care for all patients. Program developers should be especially sensitive to minimizing barriers to access among patients who are disadvantaged by reason of ethnic, cultural, and socioeconomic barriers, or who have especially complex medical conditions, and should take positive steps to improve access to care for such patients.
- Programs should aim to achieve equity in quality assessment for patients and their physicians, regardless of the setting in which care is delivered or the location of the population served (for example, inner city or rural

areas). This challenge will be particularly difficult in practice settings that lack the needed infrastructure, including EHRs.
- Programs should be "risk-adjusted" to reflect the important effects of patient non-adherence on performance outcomes. This is especially important when patient adherence is not reasonably under the control of the physician.

Paying for Performance (P4P)

- Criteria, methodology, and background data for P4P on measures of quality and cost should be transparent to all involved. Practices involved with these incentives should have an opportunity to review their data and, preferably, begin improvement prior to the implementation of the incentives.
- Monitor evidence on pay for performance and its effect on improving quality indicators in diverse practice settings.
- Funding of P4P initiatives should come from additional resources. Financial incentives should not come from a redistribution of current physician and other health care provider reimbursement.
- Requirements to achieve P4P goals should be made known to physicians in a timeframe that will allow them to safely alter the care they deliver in order to meet the goals.
  Incentives should seek to move practices to the "next level" in terms of acquiring essential structural components (for example tracking systems or EHRs) that will improve processes or outcomes of care.
- P4P pilots should use incentives of sufficient magnitude to influence physician behaviors. Results should be carefully monitored to ensure that the intended objectives are met and that unexpected detrimental effects have not been introduced.
- P4P incentives should be aligned and standardized across payers, physician practices, and hospitals.
- Pay-for-performance statistics shall be applied only to those patients to whom the peer-reviewed medical evidence is applicable, including such criteria as: demographic characteristics, clinical characteristics, clinical significance, and life expectancy.

(HP)

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society will advocate to payers that pay-for-performance statistics shall apply only to those patients to whom the peer-reviewed medical evidence is applicable, including such criteria as: demographic characteristics, clinical characteristics, clinical significance, and life expectancy. *(D)*

MMS House of Delegates, 12/7/13
(Item 2 of 2 Sunset; Time-Specific Directive Completed)

The MMS, working with provider organizations and health plans, will conduct an evaluation of current physician performance measurement activities to determine how closely the organizations conform with MMS "Principles for Profiling Physician Performance."

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates 5/11/13

Tiering

The MMS strongly supports efforts to improve the quality and cost-effectiveness of health care and is committed to working closely with other parties to these ends. In the Society's view, the essential elements of effective programs for monitoring the quality and costs of health care include the following:

- Quality measures that are clinically meaningful and directed at outcomes as well as processes of care
- Use of accurate and timely data
- Focus on results that are directly attributable to the physician's performance
- Analyses of data that are appropriate to the questions being addressed and are effectively risk-adjusted
- Effective steps to correct data inaccuracies or misinterpretations before data are released to outside parties: i.e., insurers, employers, or the public
- Public reports that are easily and accurately interpreted
- Incentives aimed at rewarding better physicians or hospitals based on important differences in clinical outcomes or the cost-effectiveness of care

General Principles: Derived from these critical elements, the Society believes that all programs aimed at quality monitoring or public reporting should:

1. Aim to Strengthen Patient-Physician Relationships: Programs that report on the quality and efficiency of health care should be directed at supporting and improving patient-physician relationships and facilitating access to care regardless of the health condition, demographics, ethnicity, economic circumstances, or treatment adherence patterns.

2. Involve Physicians in the Design and Implementation of All Programs: Practicing physicians, hospitals, and their professional organizations should be intimately involved in the design and implementation of such programs. Criteria used to judge physician performance should be jointly developed and approved by physicians and other involved parties. Moreover, physicians should be involved in monitoring ongoing programs, evaluating their effects, and modifying them in response to evidence of their effectiveness.

3. Use Clinically Important and Sound Performance Measures: All quality, cost-effectiveness, and efficiency measures should be evidence-based to the maximum extent feasible, valid, reliable, broadly accepted, and clinically meaningful. To facilitate alignment of measurement goals, selected measures should be consistent with the principles and measures supported by major national or regional organizations, including the AMA's Physician Performance Consortium, Ambulatory Care Quality Alliance (AQA) Beneficiary Quality Improvement (BQI), National Quality Forum, the Joint Commission, Massachusetts Health Quality Partners, and the Centers for Medicare and Medicaid Services. Moreover, every effort should be made to select measures that will avoid unintended harmful consequences.

4. Insure Sample Sizes Adequate to Support Meaningful Data Analysis: Variations among practices and small sample sizes often preclude meaningful assessment and public reporting of physician performance at the level of individual physician practices. In these cases, analyses should be directed at group practices, integrated health care systems, or independent physician associations with sample sizes sufficient to adequately "power" analyses.

5. Rely on Meaningful Data and Analytic Techniques:
- Input data should be accurate and timely.
- Analyses should adjust for differences in clinical case-mix, socioeconomic factors, and outliers that may distort overall results.
- Data attributed to an individual physician should be directly attributable to patients, diagnoses, and care provided by that physician. If the data apply to care received by patients treated by a practice or network, results should be attributed to that practice or network and not to individual physicians.
- Evaluation of efficiency measures should be adjusted for variations in the cost of delivering care that are outside the provider's control (e.g., variations in payer mix, area wage-index, and state-mandated requirements).
- Timely feedback should be provided to physician practices to permit errors to be corrected prior to public release to facilitate improvement in the quality and efficiency of care.

6. Share and Review Data with Physicians or Practices Prior to Public Release: Results should be shared with the physicians or hospitals being monitored before public reporting or decisions about levels of performance. The inherent tension between the need for timely data and data accuracy needs to be addressed. At the same time, reasonable efforts need to be made to limit undue burdens on physician practices to provide or evaluate data.

7. Ensure Transparency of All Quality and Cost-Effectiveness Measures and Methods: Complete descriptions of all measures, criteria, algorithms, methodologies, and data sources should be made available in writing to all parties. Preferably, these should also be Web-available.

8. Identify and Consider Practice Characteristics That May Require Special Attention in Quality and Cost-Effectiveness Monitoring: Physician practices that are new, small, located in rural locations, or serve socioeconomically deprived populations or racial minorities may need to be assessed by different criteria than other practices.

9. Use Uniform Reporting Formats: Standardized and easily understood reporting formats are critical to achieving adequate understanding and appropriate use of reports by all involved parties: physicians, health care organizations, insurers, and the public.

10. Minimize Unintended Harmful Consequences of Quality and Cost-Effectiveness Monitoring and Public Reporting: Programs aimed at improving access, quality, and/or the cost-effectiveness of health care need to have in place explicit efforts to identify and correct any unintended adverse consequences.
11. Be Pre-Tested Before Implementation: It is critical that all quality and cost-effectiveness monitoring and public-reporting initiatives receive thorough and independent pre-testing prior to implementation. Such pre-testing should be

applied to individual measures, program strategies, and efforts to rank or reward individual practices or physicians. *(HP)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates 5/17/14

The Massachusetts Medical Society (MMS) opposes implementation of physician tiering mechanisms as cost containment or quality assurance programs unless and until the underlying measurements and methodology are validated.

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

PUBLIC HEALTH

Advance Directives/Health Care Proxy
That the MMS, in collaboration with other appropriate entities, propose legislation to address the need to expedite the medical decision-making process for incompetent patients lacking a health care proxy. (D)

MMS House of Delegates, 5/17/14

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

MMS House of Delegates, 12/1/12

The Massachusetts Medical Society will work with hospitals, medical schools and other interested organizations to develop and distribute educational materials to improve physician and patient knowledge of and implementation of health care proxies.

The Massachusetts Medical Society will continue to work with hospitals, medical schools, and other interested organizations to develop public education materials and programs to improve understanding of and increase utilization of advance directives, including health care proxies.

MMS House of Delegates, 5/19/95
Reaffirmed MMS House of Delegates, 5/31/02
Item 1: Reaffirmed MMS House of Delegates, 5/8/09
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/8/09
(Reaffirmed for One Year Pending New Policy Submission at A-17)

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

The MMS will sponsor the promotion and dissemination of educational information to assist its members with having the difficult conversations concerning serious illness and end-of-life care with patients and their families. *(D)*

MMS House of Delegates, 5/18/07
Item 1: Amended and Reaffirmed MMS House of Delegates, 5/17/14
Item 2: Reaffirmed MMS House of Delegates, 5/17/14

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

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

Antibiotics/Agricultural Animals
The Massachusetts Medical Society will provide appropriate means to educate the public about the antibiotic resistance in human pathogens that arises from the excessive use of non-therapeutic doses of antibiotics in factory farm animals. *(D)*

The Massachusetts Medical Society will advocate for legislation and regulation(s) that prohibit use of non-therapeutic antibiotics in farm animals in the Commonwealth. *(D)*

MMS House of Delegates, 12/7/13

The Massachusetts Medical Society (MMS) is supportive of the reduction of overall antibiotic use in agricultural animals raised in the United States and in animals from which meat or other food products are imported to the United States. *(HP)*

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

Concussion
The Massachusetts Medical Society adopts the following adapted policies/directives from the American Medical Association and the American Association of Neurological Surgeons:

The MMS will continue to work:

a. With other organizations to increase athletic safety by promoting concussion awareness, including the fact that even mild cases of traumatic brain injury may have serious and prolonged consequences
b. With other organizations to develop a program of public education designed to underscore the importance of prevention, diagnosis, and proper treatment of concussion and other brain-related injuries
c. With appropriate state and specialty medical societies to enhance opportunities for continuing medical education
d. With sports-governing bodies, as well as players, coaches and administrators, to ensure that an athlete who exhibits symptoms associated with these types of injuries is properly evaluated, treated, and cleared before they are allowed to return and participate in sports

(D)

The MMS supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations. *(HP)*

The MMS encourages research on sports-related concussions, such as to:

a. Identify determinants of concussion
b. Assess the short- and long-term consequences of repetitive head impacts
c. Develop and evaluate risk-reduction measures
d. Develop methods to improve diagnostic accuracy, reduce the dependence on self-reporting, and inform better guidelines *(HP)*

MMS House of Delegates, 12/3/16

Emergency Preparedness
The Massachusetts Medical Society recognizes that emergency preparedness awareness and disaster response training are an essential part of public health and will work to engage physicians in preparedness efforts because of the critical role they play in limiting the medical, including psychological, impact of disasters on individuals and the community. *(HP)*

The Massachusetts Medical Society supports the development of emergency preparedness and disaster response resources for physicians in order to increase awareness and knowledge of emergency preparedness structure, response, agencies, and trainings. *(D)*

MMS House of Delegates, 12/7/13

The Massachusetts Medical Society (MMS) will continue to work in collaboration with appropriate local, state, and federal public health agencies and others responsible for disaster management to develop and implement a comprehensive and integrated education, communications, and strategic response plan for the physician community to protect the health and safety of our patients and our communities in the event of a disaster.

The MMS will emphasize and advocate for the importance of routine child and adult immunizations, such as tetanus and influenza, as a first step in preparedness.

Other basic public health functions, such as statewide trauma care and hospital capacity, will be included in the preparedness planning process and final plans.

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

The Massachusetts Medical Society (MMS) recognizes the reality that an infectious disease outbreak, terrorist attack, or other catastrophic event can occur at any moment with the potential to cause severe morbidity and mortality. The

MMS is dedicated to enhancing and continually improving the planning, mitigation, response and recovery activities needed to protect the health of the Commonwealth. *(HP)*

The MMS Committee on Preparedness will work in collaboration with local, state, and federal public health agencies, hospitals, and others responsible for emergency preparedness and disaster management, on the development, coordination, and facilitation of educational initiatives, communications systems, and integrated response plans for the medical community to minimize the consequences of natural or man-made disasters and other public health emergencies. The Committee on Preparedness will incorporate into its work advocacy for adequate resources, for populations with special medical needs during disasters, and for community engagement in all phases of preparedness planning. *(D)*

The Committee on Preparedness will endeavor to assist physicians and other health care professionals in their preparedness efforts with planning and response tools and other resources, and will encourage them to volunteer with MA Responds, the Massachusetts centralized volunteer management system, in order to enhance the state's capacity to respond to health emergencies. *(D)*

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

Fitness Trainer Certification
The Massachusetts Medical Society encourages its members to become aware of quality fitness trainer certification programs, such as those offered by the American College of Sports Medicine.

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

Full-Body Airport Scanners
The MMS will review and consider sharing any forthcoming AMA statements on the safety of full-body airport scanners with specialty societies and appropriate state agencies. *(D)*

MMS House of Delegates, 5/21/11

Genetically Engineered Foods
The MMS supports mandatory premarket systematic safety assessments of bioengineered foods and encourages: (a) development and validation of additional techniques for the detection and/or assessment of unintended effects; (b) continued use of methods to detect substantive changes in nutrient or toxicant levels in bioengineered foods as part of a substantial equivalence evaluation; (c) development and use of alternative transformation technologies to avoid utilization of antibiotic resistance markers that code for clinically relevant antibiotics, where feasible; and (d) that priority should be given to basic research in food allergenicity to support the development of improved methods for identifying potential allergens. The FDA is urged to remain alert to new data on the health consequences of bioengineered foods and update its regulatory policies accordingly. *(HP)*

The MMS supports continued research into the potential consequences to the environment of bioengineered crops including the: (a) assessment of the impacts of pest-protected crops on nontarget organisms compared to impacts of standard agricultural methods, through rigorous field evaluations; (b) assessment of gene flow and its potential consequences including key factors that regulate weed populations; rates at which pest resistance genes from the crop would be likely to spread among weed and wild populations; and the impact of novel resistance traits on weed abundance; (c) implementation of resistance management practices and continued monitoring of their effectiveness; (d) development of monitoring programs to assess ecological impacts of pest-protected crops that may not be apparent from the results of field tests; and (e) assessment of the agricultural impact of bioengineered foods, including the impact on farmers. *(HP)*

The MMS recognizes the many potential benefits offered by bioengineered crops and foods, does not support a moratorium on planting bioengineered crops, and encourages ongoing research developments in food biotechnology. *(HP)*

The MMS urges government, industry, consumer advocacy groups, and the scientific and medical communities to educate the public and improve the availability of unbiased information and research activities on bioengineered foods. *(HP)*

MMS House of Delegates, 5/7/16

The MMS will provide appropriate courses and/or web-based information to MMS members on genetically engineered foods. *(D)*

MMS House of Delegates, 5/11/13

Hand Washing
The Massachusetts Medical Society advocates hand washing as a simple, safe, effective method to prevent infectious disease for the general population, and in particular prior to eating and preparing food.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

Healthy Lifestyle/Aging
The MMS recommends that adults consume a diet higher in vegetables, fruits, whole grains, low- or non-fat dairy, seafood, legumes, and nuts; lower in red and processed meat; and low in sugar-sweetened foods and drinks and refined grains. *(HP)*

The MMS supports government-sanctioned guidelines outlining a diet higher in vegetables, fruits, whole grains, low- or non-fat dairy, seafood, legumes, and nuts; lower in red and processed meat; and low in sugar-sweetened foods and drinks and refined grains; as well as policy and regulations promoting the production and distribution of elements of such a diet. *(HP)*

The MMS recommends increased physical activity for all adults and supports policies and regulations to promote physical activity, such as safe neighborhoods in which to walk. *(HP)*

The MMS supports policy and regulations to promote maintenance of meaningful involvement of elders in all spheres of social and work life, including employment, transportation, and housing. *(HP)*

MMS House of Delegates, 5/7/16

Helmets
The Massachusetts Medical Society will continue to support wide access to and the wearing of bicycle helmets. *(D)*

The Massachusetts Medical Society will petition for legislation to change bicycling laws so that all people, regardless of age, are required to wear helmets and encouraged to wear highly-visible waist-up clothing while bicycling. Such clothing should be fluorescent with reflective areas for visibility both during daylight and darkness. *(D)*

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society (MMS) supports the use of helmets in skiers and snowboarders, particularly in children and adolescents. *(HP)*

The MMS will develop educational materials, that can be distributed to the public via the MMS website, encouraging the use of helmets in high velocity and high impact sports, including but not limited to, bicycling, motorcycle use, skiing, and snowboarding. *(D)*

MMS House of Delegates, 5/8/09
Item 1: Reaffirmed MMS House of Delegates, 5/7/16
Item 2: Amended and Reaffirmed MMS House of Delegates, 5/7/16

Human Medicine, Veterinary Medicine, and Environmental Sciences
The Massachusetts Medical Society supports and promotes collaboration among the health professions to improve the integration of human medicine, veterinary medicine, and the environmental sciences. *(HP)*

The MMS will engage in a dialogue with the Massachusetts Veterinary Medical Association and the Massachusetts Public Health Association to determine and implement strategies for enhancing collaboration among the human medical, veterinary medical, and environmental sciences professions in medical education, clinical care, public health, and biomedical research. *(D)*

MMS House of Delegates, 12/3/11

Impaired Drivers
The Massachusetts Medical Society supports initiatives that improve driving safety, such as periodic re-testing of drivers in increased-risk categories, promotion of alternative modes of transportation, and improved patient education about driving responsibly.

MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
(Reaffirmed for One Year Pending New Policy Submission at A-17)

Influenza Vaccination/Other Vaccinations *(Please See Additional Policy under Emergency Preparedness)*
That, in the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians and health care workers who have direct patient care responsibilities or potential direct exposure have an ethical obligation to accept immunization unless there is a recognized medical reason to not be immunized. In such scenarios when a physician or health care provider has not been immunized due to medical reasons, appropriate protective measures should be taken. *(HP)*

MMS House of Delegates, 12/5/15

The MMS supports efforts by the Massachusetts Department of Public Health (DPH) and other health care organizations and institutions to maximize annual seasonal influenza immunization rates for all direct patient contact health care personnel without medical contraindications through all appropriate means. If other means are unsuccessful at maximizing immunization rates, then the MMS supports mandatory immunization programs. *(HP)*

The MMS recommends that the DPH collect and share data from health care institutions on seasonal flu vaccination rates of health care personnel with direct patient contact, as well as, but disaggregated from, personnel without direct patient contact. *(D)*

MMS House of Delegates, 12/3/12
(substitute for 5/12/11 policy)

The Massachusetts Medical Society will promote access for seasonal influenza immunization for all populations identified by the Centers for Disease Control and Prevention. *(HP)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14

The Massachusetts Medical Society will promote increased flu vaccination rates, and work to ensure access to flu vaccine for high-risk populations.

The Massachusetts Medical Society supports efforts to increase and stabilize the U.S. influenza vaccine supply.

The Massachusetts Medical Society will work to increase influenza vaccination rates among health care workers as recommended by the Advisory Committee on Immunization Practices.
The Massachusetts Medical Society recommends that patients be provided with documentation of influenza vaccination for inclusion in their medical record, when the vaccination is provided by someone other than the patient's primary care provider.

The Massachusetts Medical Society encourages improved communication about vaccine supply and distribution between flu vaccine manufacturers, distributors, government, health care providers and the public.

The Massachusetts Medical Society will provide online resources to educate physicians about flu vaccine ordering and distribution processes, and office preparedness for vaccine shortages and delays.

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

LGBT Patients/Matters *(Please Also See Policies under "Civil/Human Rights, Nondiscrimination" and "Medical Education, LGBT Patients and Students")*
The Massachusetts Medical Society affirms that transgender prisoners should be allowed to be placed in facilities that are reflective of their affirmed gender identity regardless of surgical status, if they so choose. *(HP)*

The MMS will advocate to the AMA for policy supporting the ability of transgender prisoners to choose to be placed in facilities that are reflective of their affirmed gender status. *(D)*

MMS House of Delegates, 12/3/16

The Massachusetts Medical Society (MMS), as a three-year pilot, will annually offer a grant of up to $4,000 for medical students, residents and/or fellows from different institutions in the state to be used for curriculum development or to produce research that addresses lesbian, gay, bisexual, and transgender health disparities. Total MMS allocation will not exceed $16,000 per year. *(D)*

The LGBT Research Grant recipients will present their curriculum or research annually to the MMS with distribution to our membership. (D)

The procedures for administration of the LGBT Research Grant(s) shall be determined by the Board of Trustees. (D)

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society encourages all hospitals to participate in ongoing institutional assessments of their policies and practices related to lesbian, gay, bisexual, and transgender patients and families using appropriate instruments so they can address areas in their current policies and procedures that need to be appropriately updated. *(D)*

MMS House of Delegates, 5/19/12

The MMS adopts the following policy statement, adapted from American Medical Association policy H-160.991, Health Care Needs of the Homosexual Population, (reaffirmed 2007):

Health Care Needs of the Lesbian, Gay, Bisexual, and Transgender (LGBT) Population
The Massachusetts Medical Society (MMS):

(a) believes that the physician's nonjudgmental recognition of sexual orientation, behavior, and gender identity enhances the ability to render optimal patient care in health as well as in illness. This is especially true in the case of the homosexual patient, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the LGBT community and through a cooperative effort between the physician and the homosexual patient, effective progress can be made in treating the medical needs of this particular segment of the population;

(b) is committed to taking a leadership role in:
- (i) educating physicians on the current state of research in and knowledge of LGBT health and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education;
- (ii) educating physicians to recognize the physical and psychological needs of their LGBT patients;
- (iii) encouraging the development of educational programs for LGBT patients to acquaint them with the diseases for which they are at risk;
- (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT patients so that all physicians will achieve a better understanding of the medical needs of this population; and;
- (v) working with the LGBT community to offer physicians the opportunity to better understand the medical needs of homosexual, bisexual, and transgender patients; and

(c) opposes the use of "reparative" or "conversion" therapy that is based upon the assumption that homosexuality per se is a mental disorder or based upon the a priori assumption that the patient should change his or her homosexual orientation.
(HP)

The MMS will educate physicians regarding:
(a) the need for women who have sex exclusively with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and *(D)*

(b) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men. *(D)*

The MMS supports appropriate partnering medical organizations including but not limited to groups such as district medical societies, the Gay and Lesbian Medical Association, and the Massachusetts Medical Society Alliance, among others, in educating women who have sex exclusively with women on the need for regular cancer screening exams, the risk of sexually transmitted infections, and appropriate safe sex techniques to avoid that risk. *(HP)*

The MMS will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern, in order to provide the most comprehensive and up-to-date education and information to physicians to enable the provision of high-quality and culturally competent care to LGBT patients. *(D)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

Marketing of Candy Containing Hemp Oil
That the MMS encourage the U.S. Food and Drug Administration to restrict the advertising of substances marketed in ways that could promote the use of illicit drugs among children. *(HP)*

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

Men's Health
The Massachusetts Medical Society (MMS) promotes the establishment of an Office of Men's Health at the U.S. Department of Health and Human Services to coordinate outreach and awareness efforts on the federal and state levels, promote preventive health behaviors for men, and provide a vehicle whereby researchers on men's health can collaborate and share information and findings. *(D)*

MMS House of Delegates, 11/4/06
Item 1 of 2:Reaffirmed MMS House of Delegates, 5/11/13
(Item 2: Sunset)

Mouth Guards
The Massachusetts Medical Society (MMS) supports the use of mouth guards in all contact and collision sports, particularly in children and adolescents. *(HP)*

The MMS will develop educational materials encouraging the use of mouth guards in contact and collision sports for distribution to the public, including school, intramural, community, recreational, and club team coaches, via existing MMS communication channels. *(D)*

The MMS will encourage the Massachusetts Department of Public Health to include information on the benefits of mouth guard use in contact and collision sports on its Injury Prevention and Control Program web page. *(D)*

MMS House of Delegates, 5/2/15

Obesity/Overweight/Weight Stigma
The Massachusetts Medical Society recognizes that weight stigma in the health care setting leads to disparity of care and poorer health outcomes in patients with obesity. *(HP)*

The Massachusetts Medical Society will develop and promote educational information to physicians and physicians in training about weight stigma. *(D)*

The MMS will advocate for legislative policies and institutional practices to prevent weight stigma. *(D)*

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

The Massachusetts Medical Society will encourage the development of, and access to, physician-led, multidisciplinary weight management teams by advocating that third party payers cover evidence-based services, including behavioral, pharmacological, and surgical interventions, provided by these teams for patients with obesity. *(D)*

MMS House of Delegates, 12/1/12
Amended and Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society (MMS) recognizes overweight and obesity as serious health concerns for adults, adolescents, and children. *(HP)*

The MMS will work with managed care organizations and other third-party payors to better serve patients and to improve the quality, availability, and reimbursement for services aimed at preventing and treating overweight and obesity and associated comorbidities in all patients. *(D)*

The MMS promotes physician awareness of overweight and obesity and encourages physicians to take an active role in recognizing and addressing overweight and obesity and associated comorbidities in their patients. *(HP)*

The MMS promotes education about the health risks of overweight and obesity and encourages individuals to adopt healthy lifestyle behaviors (e.g. diet, exercise, sleep, and stress). *(HP)*

The MMS will continue to evaluate evidence for and support appropriate clinical, public health, and legislative measures to reduce and prevent the incidence of overweight and obesity through promotion of healthy lifestyles. *(HP)*

MMS House of Delegates, 5/12/06
MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/7/16

Oral Health
The Massachusetts Medical Society will advise physicians via existing communication venues, on common oral conditions, risk factors, and healthy behaviors as well as the medical, functional, emotional, and social consequences of poor oral health. *(D)*

The Massachusetts Medical Society will support efforts to make basic dental care accessible and affordable for all and available to homebound and nursing home patients as well as ambulatory patients. *(D)*

MMS House of Delegates, 5/7/16

Organ Donation
The Massachusetts Medical Society (MMS) supports efforts to teach health professionals about the realities and benefits of tissue and organ donation, and how to communicate this information to their patients.

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

The MMS encourages the public to sign organ donor cards and inform their families of their wish to be organ donors.

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

Performance Enhancing Drugs
The Massachusetts Medical Society calls upon its members and all physicians to oppose the use of performance enhancing drugs for the purpose of trying to improve athletic performance or for any purpose other than that which is medically indicated.

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

Physical Activity/For Students
The MMS recognizes physical activity in adults and children as important to maintaining good health and promote opportunities for physical activity for adults and children. (HP)

MMS House of Delegates, 5/12/06
MMS House of Delegates, 5/11/13
Amended and Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society support legislation to require all public and private schools in the Commonwealth to provide a minimum of 30 minutes of physical activity per day at the elementary school level and a minimum of 45 minutes of physical activity per day at the middle and high school levels. *(D)*

MMS House of Delegates, 11/3/07
Reaffirmed MMS House of Delegates, 5/17/14

Pre-Hospital Stroke Protocol
The MMS supports efforts to encourage early recognition of signs and symptoms of stroke and activation of the 911 emergency system, in order to promote early diagnosis and treatment of stroke. *(D)*

MMS House of Delegates, 5/19/12

Public Safety
The Massachusetts Medical Society is opposed to statutory penalties on health care professionals who are protecting the interests of patients with regard to the allocation or rationing of limited medical resources. *(HP)*

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

Safe Eclipse Observation
The MMS supports the development of public safety messages for safe observation of eclipses being created by the American Astronomical Society. *(HP)*

The MMS presidential officers in consultation with the Committees on Public Health and Communications will review the public safety messages for safe observation of eclipses when developed by the American Astronomical Society for consideration of MMS endorsement. *(D)*

MMS House of Delegates, 5/2/15

State Funding for Disease Control Programs
The Massachusetts Medical Society (MMS) will support funding by the Commonwealth of Massachusetts for public health efforts to reduce the incidence of tuberculosis (TB) through surveillance, education, and clinical services. *(D)*

The MMS will advocate for the maintenance of funding levels for the Massachusetts Tobacco Control Program and other public health programs for disease control and prevention administered by the Commonwealth of Massachusetts Department of Health by seeking additional fiscal resources, either through new sources or increased use of reserves and trust accounts. *(D)*

MMS House of Delegates, 5/31/02
Amended and Reaffirmed MMS House of Delegates, 5/8/09
Reaffirmed MMS House of Delegates, 5/7/16

State Laboratory
The Massachusetts Medical Society will advocate for appropriate state funding of the Hinton State Laboratory in order to successfully maintain existing responsibilities and manage ongoing and increasing needs for infrastructure, facilities, personnel, and services. *(D)*

MMS House of Delegates, 12/7/13

PUBLIC RELATIONS

The Massachusetts Medical Society will promote a “doctor for a day” initiative in the medical office/clinic environment for legislators and administrators and/or their staff in order better to communicate the practical realities and challenges of the medical practice environment. *(D)*

MMS House of Delegates, 12/3/11

The Massachusetts Medical Society’s (MMS) District Leadership Council will explore the merits of creating a statewide High School Doctor for a Day Program to be jointly sponsored by the MMS and the district medical societies through the Society’s three regional offices.

The MMS, through the District Leadership Council, will continue to assist in the financial support of district-based programs (such as the High School Doctor for a Day Program) via Grants-in-Aid, while allowing the districts to select dates and venues that are reasonable for the specific districts.

The MMS’s regional offices will be available to work with interested district medical societies to plan a High School Doctor for a Day Program.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society shall incorporate information into existing and ongoing communications activities about the education, skills and role of physicians in providing comprehensive patient care, including the scope of physician activities beyond the patient encounter, such as record keeping, consultation with colleagues, continuing medical education, and other efforts required to deliver optimal patient care in the current restrictive environment.

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

REPRODUCTIVE HEALTH

Emergency Contraception

The MMS advocates for hospitals or health care facilities to educate survivors of sexual assault about emergency contraception as well as to provide emergency contraception if the sexual assault survivor so chooses. *(HP)*

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

The Massachusetts Medical Society (MMS) supports the House of Delegates of the American Medical Association (AMA) Policy H-75.985, Access to Emergency Contraception, which states: It is the Policy of our AMA: (1) that physicians and other health care professionals should be encouraged to play a more active role in providing education about emergency contraception, including access and informed consent issues, by discussing it as part of routine family planning and contraceptive counseling; and (2) to enhance efforts to expand access to emergency contraception, including making emergency contraception pills more readily available through hospitals, clinics, emergency rooms, acute care centers, and physicians' offices. (CMS Rep. 1, I-00).

The MMS supports providing emergency contraceptive medication to patients on an over-the-counter basis.

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

The MMS requests all payers of health services including Medicaid, Medicare, and all health insurers and health plans to include contraceptives, including emergency contraceptives, in their pharmacy benefits programs.

The MMS through legislation and administrative regulation shall require insurers to allow contraceptive medication refills in a timely fashion to maximize compliance.

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

The MMS supports legislative and regulatory efforts to provide emergency contraception directly to female patients of child bearing age in a medically sound and safe way.

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Item 3 of Original: Amended and Reaffirmed MMS House of Delegates, 5/19/12
(Items 1 and 2 of Original: Sunset)

Drug Use

The Massachusetts Medical Society recognizes the autonomy of all patients, including pregnant women, and strongly opposes legislative interference in clinical decision making when a woman is found to have used or is using illicit or therapeutically prescribed narcotics during pregnancy. *(HP)*

The MMS recognizes that pregnant women with substance misuse or abuse disorders require diagnosis and treatment for the benefit of mother and fetus. The MMS opposes the criminalization of substance use on the basis of pregnancy, including via the misuse of existing child endangerment or child abuse laws that were not intended for this purpose. *(HP)*

MMS House of Delegates, 12/6/14

Fertility Treatments

The MMS will continue to support the current state mandate for expansion of coverage to include infertility treatments for members covered under plans that include pregnancy-related benefits to the same extent benefits are provided for other pregnancy-related procedures.

MMS House of Delegates, 5/17/14

Marijuana Use (Please Also See Drugs and Prescriptions)

The MMS adopts the following adapted from the American College of Obstetrics and Gynecology Committee Opinion No. 637, adopted July 2015:

- Before and during pregnancy, all women should be asked about their use of tobacco, alcohol, other drugs (including marijuana), and medications used for nonmedical reasons.
- Women reporting marijuana use should be counseled about concerns regarding potential adverse health consequences of use during pregnancy.
- Women who are pregnant or contemplating pregnancy should be encouraged to avoid marijuana use.
- Pregnant women or women contemplating pregnancy should be encouraged to avoid use of marijuana for medicinal purposes in favor of an alternative therapy for which there are better pregnancy-specific safety data.
- There are insufficient data to evaluate the effects of marijuana use on infants during lactation and breastfeeding, and in the absence of such data, marijuana use is discouraged.

(HP)

The Massachusetts Medical Society encourages that continuing medical education for Massachusetts licensed physicians who certify patients for marijuana for medical use include training about the risks of marijuana on reproduction, pregnancy, and breastfeeding. *(D)*

The Massachusetts Medical Society encourages physicians certifying patients for marijuana for medical use to counsel women and men of reproductive age regarding the risks of marijuana on reproduction, pregnancy, and breastfeeding. *(D)*

The Massachusetts Medical Society encourages physicians who certify female patients to receive marijuana for medical use to assess pregnancy status and contraceptive method at each visit. *(D)*

MMS House of Delegates, 12/5/15

The MMS will provide resources about the reproductive health risks related to the use of marijuana that Massachusetts physicians can use in order to counsel their patients. *(D)*

MMS House of Delegates, 5/2/15

Womens' Health Training

The MMS will work with the American Medical Association and the Accreditation Council for Graduate Medical Education to protect patient access to important reproductive health services by advocating for all family medicine residencies to provide comprehensive women's health training in contraceptive counseling, family planning, and counseling for unintended pregnancy. *(D)*

MMS House of Delegates, 5/11/13

QUALITY OF CARE

The Massachusetts Medical Society (MMS) will collaborate with MassPRO and appropriate business partners to evaluate the feasibility of providing a supportive framework to assist physicians in dealing with data repositories containing quality information to improve the practice of medicine. Evaluation will include the following:

Inventory and study how current and planned clinical data repositories can assist physicians in the care and treatment of patients, guided by our AMA/MMS Privacy and Confidentiality policies, as well as regulations promulgated under HIPAA and applicable state statutes.

Evaluate and study clinical repositories with the additional goal of assisting physicians in understanding their own "report cards," benchmarks, and other reports that easily highlight "opportunities for improvement," based on MMS/AMA-approved, evidence-based standards. *(D)*

The MMS will evaluate funding resources that might be available to physicians to better understand the use of clinical data repositories and data warehouses. *(D)*

The MMS will encourage collaboration between the MMS and organizations developing repositories to ensure accuracy, transparency of algorithms, scalability, and interoperability features that facilitate use in the many and varied settings where physicians practice. *(D)*

The MMS will promote clinical data repository features (standards-based data exchange, ease of use, clinically relevant reports) that support the dissemination of interoperable electronic medical records that promote and enhance the physician-patient relationship, in concert with other local and national efforts, such as the Massachusetts eHealth Collaborative and Medem. *(D)*

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

(Item 5 of Original Sunset)

Patient Safety
The MMS will encourage the use of culture of safety surveys by physicians in their medical offices and where applicable in ambulatory surgical centers where they work. *(D)*

MMS House of Delegates, 5/7/16

The Massachusetts Medical Society accepts the Institute of Medicine's (IOM) recommendations on Identifying Priority Areas for Quality Improvement, IOM Report *Priority Areas for National Action, Transforming Health Care Quality* (2003):

1. That the priority areas collectively:
   - Represent the U.S. population's health care needs across the lifespan, in multiple health care settings involving many types of health care professionals.
   - Extend across the full spectrum of health care, from keeping people well and maximizing overall health; to providing treatment to cure people of disease and health problems as often as possible; to assisting people who become chronically ill to live longer, more productive, and comfortable lives; to providing dignified care at the end of life that is respectful of the values and preferences of individuals and their families.

2. Use of the following criteria for identifying priority areas:
   - Impact – the extent of the burden – disability, mortality, and economic costs – imposed by a condition, including effects on patients, families, communities, and societies.
   - Improvability – the extent of the gap between current practice and evidence-based best practice and the likelihood that the gap can be closed through change in an area; and the opportunity to achieve dramatic improvements in the six national quality aims identified in the Quality Chasm report (safety, effectiveness, patient-centeredness, timeliness, efficiency and equity).
   - Inclusiveness – the relevance of an area to a broad range of individuals with regard to age, gender, socioeconomic status, and ethnicity/race (equity); the generalizability of associated quality improvement strategies to many types of conditions and illnesses across the spectrum of health care (representativeness); and the breadth of change effected through such strategies across a range of health care settings and providers (reach).

3. That DHHS, along with other public and private entities, focus on the following areas for transforming health care:
   - Care coordination (cross-cutting)
   - Self-management/health literacy (cross-cutting)
   - Asthma – appropriate treatment for persons with mild/moderate persistent asthma
   - Cancer screening that is evidence-based – focus on colorectal and cervical cancer
   - Children with special health care needs
   - Diabetes – focus on appropriate management of early disease
   - End of life with advanced organ system failure – focus on congestive heart failure and chronic obstructive pulmonary disease
   - Frailty associated with old age – preventing falls and pressure ulcers, maximizing functions, and developing advanced care plans
   - Hypertension – focus on appropriate management of early disease
   - Immunization – children and adults
   - Ischemic heart disease – prevention, reduction of recurring events, and optimization of functional capacity
   - Major depression – screening and treatment
   - Medication management – preventing medication errors and overuse of antibiotics
   - Nosocomial infections – prevention and surveillance
   - Pain control in advanced cancer
   - Pregnancy and childbirth – appropriate prenatal and intrapartum care
   - Severe and persistent mental illness – focus on treatment in the public sector
   - Stroke – early intervention and rehabilitation
   - Tobacco dependence treatment in adults
   - Obesity (emerging area)

4. That the Agency for Healthcare Research and Quality (AHRQ), in collaboration with other private and public organizations, be responsible for continuous assessment of progress and updating of the list of priority areas. These responsibilities should include:
   - Developing and improving data collection and measurement systems for assessing the effectiveness of quality improvement efforts.
   - Supporting the development and dissemination of valid, standardized measures of quality.
   - Measuring key attributes and outcomes and making this information available to the public.
   - Revising the selection criteria and the list of priority areas.
   - Reviewing the evidence base and results, and deciding on updated priorities every 3 to 5 years.
   - Assessing changes in the attributes of society that affect health and health care and could alter the priority of various areas.
   - Disseminating the results of strategies for quality improvement in the priority areas.
5. That data collection in the priority areas:
   - Go beyond the usual reliance on disease – and procedure-based information – to include data on the health and functioning of the U.S. population.
   - Cover relevant demographic and regional groups, as well as the population as a whole, with particular emphasis on identifying disparities in care.
   - Be consistent within and across categories to ensure accurate assessment and comparison of quality enhancement efforts.
6. That the Congress and the Administration provide the necessary support for ongoing process of monitoring progress in the priority areas and updating the list of areas. This support should encompass:
   - The administrative costs borne by the AHRQ.
   - The costs of developing and implementing data collection mechanisms and improving the capacity to measure results.
   - The costs of investing strategically in research aimed at developing new evidence on interventions that improve the quality of care and at creating additional, accurate, valid, and reliable measures of quality. Such research is especially critical in areas of high importance in which either the scientific evidence for effective interventions is lacking or current measures of quality are inadequate.

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

The Massachusetts Medical Society (MMS) accepts the Institute of Medicine's (IOM) thirteen recommendations in their report, "Crossing the Quality Chasm," with an amendment to recommendation three:

Recommendation 1: All health care organizations, professional groups, and private and public purchasers should adopt as their explicit purpose to continually reduce the burden of illness, injury, and disability, and to improve the health and functioning of the people of the United States.

Recommendation 2: All health care organizations, professional groups, and private and public purchasers should pursue six major aims; specifically, health care should be safe, effective, patient-centered, timely, efficient, and equitable.

Recommendation 3: Congress should continue to authorize and appropriate funds for, and the Department of Health and Human Services should move forward expeditiously with the establishment of, monitoring and tracking processes for use in evaluating the progress of the health system in pursuit of the above-cited aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. Efforts should be made to eliminate any duplication of reporting or monitoring processes of care. The Secretary of the Department of Health and Human Services should report annually to Congress and the President on the quality of care provided to the American people.

Recommendation 4: Private and public purchasers, health care organizations, clinicians, and patients should work together to redesign health care processes in accordance with the following rules:

· Care based on continuous healing relationships. Patients should receive care whenever they need it and in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the Internet, by telephone, and by other means in addition to face-to-face visits.

· Customization based on patient needs and values. The system of care should be designed to meet the most common types of needs, but have the capability to respond to individual patient choices and preferences.

- The patient as the source of control. Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.
- Shared knowledge and the free flow of information. Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
- Evidence-based decision making. Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
- Safety as a system property. Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
- The need for transparency. The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice, or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
- Anticipation of needs. The health system should anticipate patient needs, rather than simply react to events.
- Continuous decrease in waste. The health system should not waste resources or patient time.
- Cooperation among clinicians. Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

Recommendation 5: The Agency for Healthcare Research and Quality should identify not fewer than 15 priority conditions, taking into account frequency of occurrence, health burden, and resource use. In collaboration with the National Quality Forum, the Agency should convene stakeholders, including purchasers, consumers, health care organizations, professional groups, and others, to develop strategies, goals, and action plans for achieving substantial improvements in quality in the next 5 years for each of the priority conditions.

Recommendation 6: Congress should establish a Health Care Quality Innovation Fund to support projects targeted at (1) achieving the six aims of safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity; and/or (2) producing substantial improvements in quality for the priority conditions. The Fund's resources should be invested in projects that will produce a public-domain portfolio of programs, tools, and technologies of widespread applicability.

Recommendation 7: The Agency for Healthcare Research and Quality and private foundations should convene a series of workshops involving representatives from health care and other industries and the research community to identify, adapt, and implement state-of-the-art approaches to addressing the following challenges:

- Redesign of care processes based on best practices
- Use of information technologies to improve access to clinical information and support clinical decision making
- Knowledge and skills management
- Development of effective teams
- Coordination of care across patient conditions, services, and settings over time
- Incorporation of performance and outcome measurements for improvement and accountability

Recommendation 8: The Secretary of the Department of Health and Human Services should be given the responsibility and necessary resources to establish and maintain a comprehensive program aimed at making scientific evidence more useful and accessible to clinicians and patients. In developing this program, the Secretary should work with federal agencies and in collaboration with professional and health care associations, the academic and research communities, and the National Quality Forum and other organizations involved in quality measurement and accountability.

Recommendation 9: Congress, the executive branch, leaders of health care organizations, public and private purchasers, and health informatics associations and vendors should make a renewed national commitment to building an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research, and clinical education. This commitment should lead to the elimination of most handwritten clinical data by the end of the decade.

Recommendation 10: Private and public purchasers should examine their current payment methods to remove barriers that currently impede quality improvement, and to build in stronger incentives for quality enhancement.

Recommendation 11: The Health Care Financing Administration [CMS] and the Agency for Healthcare Research and Quality, with input from private payers, health care organizations, and clinicians, should develop a research agenda to identify, pilot-test, and evaluate various options for better aligning current payment methods with quality improvement goals.

Recommendation 12: A multidisciplinary summit of leaders within the health professions should be held to discuss and develop strategies for (1) restructuring clinical education to be consistent with the principles of the 21st-century health system throughout the continuum of undergraduate, graduate, and continuing education for medical, nursing, and other professional training programs; and (2) assessing the implications of these changes for provider credentialing programs, funding, and sponsorship of education programs for health professionals.

Recommendation 13: The Agency for Healthcare Research and Quality should fund research to evaluate how the current regulatory and legal systems (1) facilitate or inhibit the changes needed for the 21st-century health care delivery system, and (2) can be modified to support health care professionals and organizations that seek to accomplish the six aims set forth in Chapter 2:

- Safe — avoiding injuries to patients from the care that is intended to help them.
- Effective — providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively).
- Patient-centered — providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
- Timely — reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient — avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable — providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

The MMS adds the following additional recommendations to the IOM recommendations:

1) Changes introduced into the health care system must honor patient confidentiality and privacy.
2) Physicians by the nature of their training and their responsibilities have a unique perspective on the health care system and their input is vital to any change. In addition, while physicians respect and value other health care professionals who work in the health care system, a broad array of physicians should be consulted when structural changes in the health care system are suggested.

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

The MMS will advocate for patient safety initiatives to be incorporated into the development of guidelines and protocols.

The MMS will continue to take a leadership role in promoting patient safety initiatives, including education, and dissemination of appropriate patient safety information to members.

MMS House of Delegates, 5/19/00
Reaffirmed MMS House of Delegates, 5/18/07
Reaffirmed MMS House of Delegates, 5/17/14
(Items 1, 2, 5, and 6 of Original: Sunset)

Quality Measurement/Quality Improvement
The MMS will keep the membership informed of identified issues with relevant implemented quality measures and advocate strongly, by whatever means appropriate to the situation, against implementation of inappropriate or inadequate quality measures.
(D)

MMS House of Delegates, 12/7/13
(Item 1o f 2 Sunset: Time-Limited Directive Completed)

The MMS will advocate through legislative or regulatory means to require that commercial medical insurers select from a standard set of quality measures to evaluate physician quality compliance. This measure would be used for financial incentive and tiering programs. *(D)*

MMS House of Delegates, 5/19/13

The Massachusetts Medical Society (MMS) will continue to participate in the Massachusetts Health Quality Partnership (MHQP) and that MMS representatives communicate appropriate information and recommendations to relevant committees and leadership.

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

The Massachusetts Medical Society adopts the following principles, for quality of medical care initiatives that the Society should undertake or embrace:

I. Definition of Quality

   A. Institute of Medicine: "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge"
   B. Physicians' perspective as patient advocates (in contrast with those of health plans, purchasers) focuses on appropriate clinical decision-making (related to knowledge and judgment) and performance skills

II. Individual Physician Responsibility for Quality Management
   A. There are professional privileges granted from society to physicians. In return, physicians have a professional responsibility to understand and apply scientific and technical knowledge for the benefit of patients (i.e., quality medical care)
   B. Physicians' claims to the public trust are derived from our unique role as patient advocates

III. Responsibilities of the Massachusetts Medical Society (MMS)

   A. Our mission states: "The purposes of the Massachusetts Medical Society shall be to do all things as may be necessary and appropriate to advance medical knowledge, to develop and maintain the highest professional and ethical standards of medical practice and health care, and to promote medical institutions formed on liberal principles for the health, benefit, and welfare of the citizens of the Commonwealth"
   B. MMS is the primary "grassroots" organization representing Massachusetts physicians
   C. Our own past history demonstrates concern for quality in areas such as continuing medical education (CME), advancement of medical knowledge through the ownership of *The New England Journal of Medicine,* and participation in guideline promulgation and implementation
   D. MMS has broad experience and readily available expertise in patient care, research, and education

IV. Many policy decisions regarding medical practice (e.g., legislative and regulatory) are at the state level. Therefore, a state medical society is the most appropriate arena for many policy decisions.

V. Role of American Medical Association

   A. Promote physician involvement in continuous quality improvement (CQI): data collection, analyses, and feedback loops
   B. Promote standards for physician profiling
   C. Promote effective quality improvement models
   D. Encourage development and provision of educational and training opportunities to improve patient care
   E. Encourage outcomes research
   F. Evaluate quality assurance programs
   G. Advocate nationally for quality in medicine

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

Quality of Medical Care Initiatives, which the Massachusetts Medical Society undertakes, should have the following characteristics:

I. Quality Measures from Physicians' Perspective: i.e., Appropriate Clinical Decision-Making, Performance Skills, and Desired Outcomes

II. Medical Services Ranging from Those Performed for Individual Patients to Those Performed for the Public Health

III. Categories of specific physician groups as participants in quality initiatives

- A. Geographic Area
- B. Specialty
- C. Impaired
- D. Outlier Practice Patterns
- E. Other Groups

IV. Conceptual Frameworks for Quality Initiatives

- A. Measurement: Profiling
  - (1) System Focus
    - a) Structures: (e.g. credentialing, liability)
    - b) Processes: (e.g. compliance to guidelines)
    - c) Outcomes: (e.g. mortality, quality of life)
  - (2) Role of Massachusetts Medical Society
    - a) Set standards for agencies to measure through the development of a set of attributes or criteria by an expert clinical panel
    - b) Direct role in the profiling of physicians
- B. Substantive Medical Management: Knowledge Base, Judgment, Decision-Making
  - (1) Curricula
    - a) Directly providing and organizing CME and Non-CME courses
    - b) Accrediting Other Physician-Affiliated Organizations
    - c) Implementing Scientific Advances in Physicians' Clinical Practices
  - (2) Mentoring
  - (3) Clinical Practice Guidelines: Refine, approve, implement, evaluate
  - (4) Other systems of support

V. Physicians Partnering with Patients, along with other Providers: Academic Consortia, Hospitals, and other Professional Organizations

VI. Establishment of a Quality of Medical Care Program

VII. Clarity of Design and Focus of the Quality of Medical Care Program

- A. Substantive content of medical program
- B. Program target population
- C. Definition of program outcomes
- D. Definition of program time-line
- E. Program evaluation component

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

Risk Contracts

The Massachusetts Medical Society will work with the health plans to develop a template with standardized language regarding what valid data should be made available to physicians in a timely manner to assist them as they undertake risk contracts and strive to improve quality and provide cost effective care. This language would be reviewed by physicians and other experts who have experience with risk contracts for their input. Final language would be widely disseminated to MMS members. *(D)*

MMS House of Delegates, 5/21/11

Sleep Medicine
The MMS supports continued delivery of high-quality care for patients with sleep disorders in Massachusetts. *(HP)*

The MMS supports incorporation of new diagnostic tools and therapies to treat sleep disorders utilizing evidence-based clinical guidelines and accreditation standards. *(HP)*

The MMS support the principle that management of chronic sleep disorders requires programs that incorporate comprehensive sleep evaluations, access to appropriate testing, evidence-based treatment protocols, and collaboration between primary care providers and sleep specialists. *(HP)*

MMS House of Delegates, 12/4/10

REGULATION AND LICENSURE

Board of Registration in Medicine
The Massachusetts Medical Society (MMS) reaffirms its support for adequate funding for the Board of Registration in Medicine.

MMS House of Delegates, 11/6/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society will work with the Board of Registration in Medicine to establish limitations for accessing physicians' medical and/or mental health treatment records when they are irrelevant to the matter under investigation.

The Massachusetts Medical Society will encourage the Board of Registration in Medicine, when it is inquiring into the medical or mental health status of a licensee, to accept a treatment summary provided by the treating physician in lieu of accessing the licensee's medical or mental health records.

If negotiations with the Board of Registration in Medicine do not result in a satisfactory response, the Massachusetts Medical Society's Committee on Legislation will seek to secure a statutory privilege protecting physicians' medical and/or mental health treatment records from access by the Board of Registration in Medicine, except and to the degree that the Board can establish a compelling need to access those portions relevant to a current investigation.

MMS House of Delegates, 11/8/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10

The Massachusetts Medical Society upholds the Massachusetts Board of Registration in Medicine as the only licensing authority in Massachusetts for physicians. The Massachusetts Medical Society condemns programs which deselect, prohibit or obstruct licensed physicians, in good standing in Massachusetts, from providing patient care.

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

Centralized Verification
The MMS encourages the use of a centralized verification and repository system to avoid repetitive verification from a primary source with each new medical licensure application.

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates 5/9/08
Reaffirmed MMS House of Delegates, 5/2/15
(Items 2-3 of Original: Sunset)

The Massachusetts Medical Society supports the principle that regulation or licensure by any body other than the Board of Medicine is extraneous, redundant, and will add to the cost of medical services, and that the MMS should act

appropriately to repeal any legislation that would require regulation or licensure of physicians by any other regulatory body.

MMS Council, 10/14/81
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Clinical Skills Assessment
The Massachusetts Medical Society will explore partnerships or collaborations with established clinical skills assessment and enhancement entities to ensure programs are available for Massachusetts physicians who need to update or document their skill levels, who have taken extended time off from clinical practice, or who want to learn new skills (including procedural and cognitive skills). *(D)*

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society strongly opposes the implementation of a routine clinical skills assessment examination as a part of the physician relicensure process, unless validated specialty-specific criteria are established and unless such an examination has been shown to provide a health benefit to the citizens of the Commonwealth. *(HP)*

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

International Medical Graduates: GME Training/Licensure
The Massachusetts Medical Society supports a decrease in the number of years of American Osteopathic Association (AOA)/Accreditation Council for Graduate Medical Education (ACGME) approved GME training required for international medical graduates (IMGs) to achieve parity with U.S. medical graduates (USMGs) in order to obtain medical licensure. *(HP)*

The Massachusetts Medical Society will aggressively advocate for a decrease in the number of years of AOA/ACGME approved GME training required for IMGS to achieve parity with USMGs in order to obtain medical licensure. *(D)*

MMS House of Delegates, 5/7/16

Maintenance of Certification & Licensure
The MMS will post publicly on its website and send notifications to the Massachusetts BRM, the FSMB, ABMS, the governor, the AMA Council on Education, and all Massachusetts state and federal legislators, to state the following: MMS policy (and the complete resolution with footnoted references) opposing Maintenance of Certification (MOC), adopted December 6, 2014, which reads as follow:

> The MMS acknowledges that the requirements within the Maintenance of Certification process are costly and time intensive, and they result in significant disruptions to the availability of physicians for patient care. *(HP)*
>
> The MMS acknowledges that after initial specialty board certification, the MMS affirms the professionalism of the physician to pursue the best means and methods for maintenance and development of their knowledge and skills. *(HP)*
>
> The MMS reaffirms the value of continuing medical education, while opposing mandatory Maintenance of Certification as a requirement for licensure, hospital privileges, and reimbursement from third party payers. *(HP)*
>
> The MMS will communicate our position regarding Maintenance of Certification to the AMA, specialty societies, universities, and physician and industry groups involved with independent continuing medical, clinical, and scientific education.
> *(D/HP)* (MMS House of Delegates, 12/6/14)

MMS House of Delegates, 5/2/15

The MMS acknowledges that the requirements within the Maintenance of Certification process are costly and time intensive, and they result in significant disruptions to the availability of physicians for patient care. *(HP)*

The MMS acknowledges that after initial specialty board certification, the MMS affirms the professionalism of the physician to pursue the best means and methods for maintenance and development of their knowledge and skills. *(HP)*

The MMS reaffirms the value of continuing medical education, while opposing mandatory Maintenance of Certification as a requirement for licensure, hospital privileges, and reimbursement from third party payers. (HP)

The MMS will communicate our position regarding Maintenance of Certification to the AMA, specialty societies, universities, and physician and industry groups involved with independent continuing medical, clinical, and scientific education.
(D/HP)

MMS House of Delegates, 12/6/14

That the Massachusetts Medical Society adopt the following principles.

Proposed Massachusetts Medical Society Principles on Maintenance of Licensure (MOL):

The Massachusetts Medical Society supports continuous lifelong learning by physicians and quality improvement in the practice of medicine; and will only support implementation of MOL requirements when substantial and convincing evidence demonstrates that such requirements will improve clinical outcomes/patient care and that the clinical benefit of these additional requirements will significantly outweigh the costs (both direct and indirect) to physicians and to society — i.e., patient access — that are associated with any additional requirements beyond those currently required for renewal of medical licenses.

That In the event that substantial and convincing evidence exists and the Massachusetts Board of Registration moves forward with implementation of Maintenance of Licensure (MOL), the Massachusetts Medical Society will support the following:

a. Any MOL activity should be integrated, wherever feasible, into the existing infrastructure of the health care environment. For example, participation in Maintenance of Certification (MOC) or Osteopathic Continuous Certification (OCC), formal hospital, clinic, or payer quality improvement/re-credentialing programs should satisfy the requirements of MOL.
b. Any MOL educational activity under consideration should be developed in collaboration with physicians, evidence-based, and specialty specific. Accountability for physicians should be led by physicians.
c. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physician's time and the impact on patient access to care, as well as a risk/benefit analysis with particular attention to unintended consequences.
d. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).
e. Any MOL activity should be designed for quality improvement and lifelong learning.
f. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity for physicians who are not specialty board certified or who are not in the process of MOC/OCC, or who have not been credentialed by a hospital or a payer.

The Massachusetts Medical Society shall seek working in collaboration with the Board of Registration in Medicine and other interested parties regarding any continuing medical education requirements during the deliberation process and before enactment.
(HP)

MMS House of Delegates, 12/7/13

"Meaningful Use" and Other Web-Based Mandates/Requirements

The Massachusetts Medical Society will work with the Commonwealth to ensure that all mandated web-based actions by physicians shall go through one universal portal. (D)

The Massachusetts Medical Society will work with the Commonwealth to promote having only one log-on requirement for all actions under the Department of Public Health and other Massachusetts agencies physicians are mandated to use, and this log-on requirement shall be issued at the time of initial licensure or re-licensure. (D)

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society stands on record as opposing the requirement that medical licensure be conditioned upon compliance with "Meaningful Use" requirements. *(HP)*

The Massachusetts Medical Society will make efforts at both the administrative and legislative levels to secure the reversal of the requirement that medical licensure be conditioned upon compliance with "Meaningful Use" requirements. *(D)*

MMS House of Delegates, 12/7/13

Step 2 Clinical Skills Exam

The MMS will advocate for the Massachusetts Board of Registration in Medicine to eliminate the United States Medical Licensing Exam Step 2 Clinical Skills Exam for licensure requirement for graduates of U.S. osteopathic and allopathic medical schools who have passed a medical school-administrated clinical skills examination. *(D)*

The MMS will advocate for the National Board of Medical Examiners and the Association of American Medical Colleges to work jointly on the creation of a mutually agreed upon standardized clinical skills examination to be administered at each U.S. medical school in lieu of Step 2 Clinical Skills Exam and as a substitute prerequisite for Step 3 and that passage of such an exam be a requirement for medical school graduation. (*D)*

MMS House of Delegates, 5/7/16

RESEARCH

Medical Research

The Massachusetts Medical Society in its program developments will take into consideration the importance of promoting and supporting medical research in the interest of the health and well-being of future generations.

MMS House of Delegates, 11/21/97
Reaffirmed MMS House of Delegates, 5/14/04
Reaffirmed MMS House of Delegates, 5/21/11

RESIDENTS

The Massachusetts Medical Society will serve as a resource to resident/fellow members who have disputes with their residency program or teaching hospital over patient care issues or working conditions.

MMS House of Delegates, 5/8/98
Reaffirmed MMS House of Delegates, 5/13/05
Amended and Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society supports hospital-based house staff associations to represent house staff interest and ideas and the general planning for medical cost cutting. The MMS supports the affiliation of house staff organizations with the MMS Resident Section.

The Massachusetts Medical Society supports continued funding for residency training. House staff currently in training programs should not have their positions cut for reasons of cost savings.

MMS Council, 10/9/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

The Massachusetts Medical Society (MMS) will continue to monitor state and federal legislative and regulatory activities regarding resident physician work hours. *(D)*

MMS House of Delegates, 11/9/02
Reaffirmed MMS House of Delegates, 5/08/09
(Item 1 of 2, Sunset)
Reaffirmed MMS House of Delegates, 5/7/16

The Massachusetts Medical Society (MMS) acknowledges that resident physician work hour excesses can negatively impact patient safety, the quality of patient care and resident physician health, safety, and well-being.

The MMS encourage all residency program directors in Massachusetts to continue to adopt resident physician work hour standards that meet evidence-based ACGME guidelines.

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

SURGERY

Ambulatory Surgery Centers

The Massachusetts Medical Society (MMS) supports the development and utilization of accredited freestanding ambulatory surgery centers as part of a multiplicity of patient care delivery options, including physician office practices and outpatient hospital care for the provision of ambulatory surgery services as a mechanism to control health care costs, ensure access to care, and provide quality patient care in the Commonwealth. *(HP)*

The MMS supports state and federal legislation that advocates for the development and utilization of accredited freestanding ambulatory surgery care centers but does not impose Determination of Need and clinic licensing standards for physician office practices and is consistent with meeting the goals of controlling health care costs, ensuring access to care, and providing quality care, however, not to imply any MMS position on "niche" or specialty hospitals. *(D)*

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

Laser Surgery

Laser surgery is a type of surgery using laser technology to cut or alter living tissue. The Massachusetts Medical Society adopts the policy that laser surgery should be performed only by individuals licensed to practice medicine and surgery, or by other categories of practitioners currently licensed by the state to perform surgery as of January 1, 1992.

MMS Council, 5/8/92
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Outpatient Surgery

The Massachusetts Medical Society (MMS) will continue to collaborate with the Massachusetts Board of Registration in Medicine (BRM) regarding the endorsement of the MMS Office-Based Surgery Guidelines for surgery and anesthesia in the office-based setting.

The MMS reaffirms its existing policy adopted at I-01 that these practice guidelines are not intended to be unique or exclusive indicators of appropriate care. Any physician should be able to demonstrate that the care rendered is safe and appropriate, even if it may vary from the guidelines in some respects.

The MMS believes that surgical and anesthesia care, regardless of where performed or by whom, should be provided in accordance with accepted standards of practice and in a manner that insures the safety of the patient during the performance of surgery, administration of and recovery from anesthesia, and at the time of discharge from the facility.

The MMS will work to refine the guidelines for surgery and anesthesia in the office-based setting on an ongoing basis as needed and forward the revisions to the BRM for incorporation.

MMS House of Delegates, 5/31/02
(Items 2, 5, 7, and 8 of Original: Sunset)
Reaffirmed and Item 1 Amended and Reaffirmed MMS House of Delegates, 5/14/10

The MMS will continue to work with the Board of Registration in Medicine (BRM) to learn about their concerns, issues, and plans regarding office-based surgery.

The MMS will continue to communicate with all relevant national and local specialty societies and to locate current statistics regarding office-based surgery trends in Massachusetts.

Practice guidelines are not intended to be unique or exclusive indicators of appropriate care. Any physician should be able to demonstrate that the care rendered is safe and appropriate, even if it may vary from the guidelines in some respects.

MMS House of Delegates, 11/17/01
Reaffirmed MMS House of Delegates, 5/9/08
(Additional Items Sunset, 5/9/08)
Reaffirmed MMS House of Delegates, 5/2/15

The MMS shall continue to monitor and evaluate existing and developing legislation in other states regarding office-based surgery, as well as evidence-based standards of care regarding office-based surgery, in order to bring that knowledge forward to the legislators, where appropriate.

MMS House of Delegates, 5/11/01
Reaffirmed MMS House of Delegates 5/9/08
(Item 1 of Original: Sunset)

Robotic Surgery/Training
The MMS opposes efforts of the legislature to develop training protocols, certification and establishing guidelines for surgeon training and experience for the use of robotic surgery. *(D)*

MMS House of Delegates 5/19/12

Standards of Care
The Massachusetts Medical Society (MMS) recognizes that minimum frequency standards may be appropriate for some surgical procedures. *(HP)*

The MMS will continue to monitor the literature and physician feedback concerning the impact and ethic of performing surgical procedures as it relates to surgical volume. *(D)*

The MMS will continue to monitor and provide feedback, when appropriate, to relevant agencies as they develop standards regarding surgical competency and minimum frequency. *(D)*

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

TECHNOLOGY

Electronic Mail
The Massachusetts Medical Society (MMS) recommends that physicians who choose to use e-mail, reference the American Medical Informatics Association (AMIA) Guidelines in Developing Procedures for Their Own Practices. *(HP)*

The MMS advises physicians who choose to use e-mail that this form of communication should not be used for urgent requests or conditions, and that physicians should advise their patients and colleagues of the same. *(HP)*

The MMS should advise physicians who choose to use e-mail that the technology commonly employed does not currently insure the security of such transmissions, unless specific measures are taken to ensure proper authentication and encryption. *(HP)*

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12
Reaffirmed MMS House of Delegates, 5/7/16

Information Technology Policy and Principles
That the Massachusetts Medical Society should support the following information technology principles and policy:

a) Physicians should have direct control over choice and management of the information technology used in their practices.
b) Information technology available to physicians must be safe, effective and efficient.
c) Information technology available to physicians should support the physician's obligation to put the interests of patients first.
d) Information technology available to physicians should support the integrity and autonomy of physicians.
e) Information technology should support the patient's autonomy by providing access to that individual's data.
f) There should be no institutional or administrative barriers between physicians and their patients' health data.
g) Information technology should promote the elimination of health care disparities.

(HP)

MMS House of Delegates, 5/7/16

Meaningful Use Requirements
The MMS shall establish a task force (to include members of the Committee on Information Technology and advisors, as necessary) charged with developing guidelines/policies on the technology mandates facing integrated practices and accountable care organizations and educating members about these mandates. *(D)*

The Massachusetts Medical Society will advocate for a more open, affordable process to meet technology mandates imposed by regulations and mandates; e.g., that all Direct secure email systems, mandated by Meaningful Use stage 2, including health information exchanges and electronic health record systems, allow a licensed physician to designate any specified Direct recipient or sender without interference from any institution, electronic health record vendor, or intermediary transport agent. *(D)*

MMS House of Delegates, 12/7/13

Social Media
That the MMS adopt as amended its social media policy, adopted at A-11, to read as follows:

MMS Social Media Guidelines for Physicians

Carefully planned and professionally executed participation in social media by physicians is professionally appropriate, and can be an effective method to connect with colleagues, advance professional expertise, educate patients, and enhance the public profile and reputation of our profession.

Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must not post any content that could be used to directly or indirectly reveal a patient's identity.

Physicians must recognize that personal and professional online content can have a significant impact on public trust in the medical profession, both positively and negatively. The content that physicians post online may also influence their reputations among patients and colleagues, and may have consequences for their medical careers, particularly for physicians in training and medical students.

When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, it is highly likely that content will remain there indefinitely, and may reach a wider audience than intended. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines, just as they would in any other context.

To maintain appropriate professional boundaries, it is recommended that physicians separate personal and professional content online, where technically feasible. Physicians should accept patient online invitations to connect only on a physician's professional or a practice's social media account, and should not accept invitations from patients to connect on their personal accounts.

Physicians' existing professional responsibility to hold their colleagues to account for maintaining the profession's code of ethics (e.g., AMA position on the necessity of reporting a colleague's unethical conduct) extends to behavior in online communities. Thus, when physicians see content posted by colleagues that appears unprofessional, they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

Physicians must disclose all relationships they have with regard to the maker or provider of products and services they review or discuss in online communities. This includes discussions and reviews of products and services provided to the physician for free.
(HP)

That the Massachusetts Medical Society will broadly disseminate the guidelines on the professional use of social media to its membership. *(D)*

MMS House of Delegates, 5/21/11
Amended MMS House of Delegates, 12/5/15

Technology in Health Care
The MMS adopts the following statement on the interoperability of medical devices:

> The MMS believes that intercommunication and interoperability of electronic medical devices (e.g., noninvasive blood pressure cuffs, EKGs, pulse oximeters) could lead to important advances in patient safety and patient care, and that the standards and protocols to allow such seamless intercommunication should be developed fully with these advances in mind. The MMS also recognizes that, as in all technological advances, interoperability poses safety and medico-legal challenges, as well. The development of standards and production of interoperable equipment protocols should strike the proper balance to achieve maximum patient safety, efficiency, and outcome benefit. *(HP)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

The Massachusetts Medical Society supports, in principle, the development of new mechanisms for the objective evaluation of health care technologies and it expresses hope that such mechanisms will include means for hastening the proper evaluation and introduction of new technologies, for example, providing for interim payment for new health care technologies which are undergoing carefully planned evaluation. A similar approach should, in due course, be applied to selected "accepted" health care technologies.

MMS Council, 10/12/83
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

TOBACCO/ SMOKING

Anti-Smoking Poster Contest
The Massachusetts Medical Society and the Massachusetts Medical Society Alliance will establish an annual, statewide elementary school anti-smoking poster contest.

MMS House of Delegates, 5/3/96
Reaffirmed MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Item 2 of Original: Sunset)

E-Cigarettes
The MMS opposes the marketing, sales, and use of e-cigarettes and other nicotine delivery products among youths, particularly for persons under the age of twenty-one. *(HP)*

The MMS will continue to work with Massachusetts state lawmakers and officials to develop strategies to prevent marketing, sales, and use of e-cigarettes and other nicotine delivery products among youths, particularly for persons under the age of twenty-one. *(D)*

MMS House of Delegates, 12/7/13
Amended (and Reaffirmed) by Implication MMS House of Delegates, 12/6/15

Liquid Nicotine Packaging *(Please See Additional Policy under Drugs and Prescriptions & Children and Youth)*
That the MMS advocate for state, local, and federal legislation and regulation to require child-resistant packaging and appropriate warning of the toxicity of this product for liquid nicotine refill products. *(D)*

MMS House of Delegates, 5/2/15

Point-of-Sale Tobacco Advertising (*Please Also See Government Initiatives in this Section)*
The MMS will work collaboratively with other organizations of similar interests to advocate for legislation in the Commonwealth to require tobacco vendors to remove tobacco products and all tobacco advertising from public view at cash registers and counters in all retail establishments, excluding shops that exclusively sell tobacco products. *(D)*

MMS House of Delegates, 12/4/10

Sale of Tobacco in Health Care Facilities/Pharmacies
The MMS will support government action to prevent the sale of tobacco in any health care facility licensed by the Commonwealth or any site where a health care provider licensed under any section of Chapter 112 of the Massachusetts General Laws practices his or her profession. *(D)*

The MMS will support government action to prohibit any individual or corporate entity from providing shared or leased space to a licensed health care facility in any site where tobacco products are sold or distributed. *(D)*

The MMS will support regulations preventing all licensed health care providers from being employed in their professional capacity by any entity selling or distributing tobacco products in the same building or site where health care services are delivered. This prohibition shall not apply to buildings or sites where tobacco sales are conducted in a site with separate street entrances more than 75 feet from the site where health services are offered and where no interior hallways provide access to both the health care facility and the site selling or distributing tobacco. *(D)*

MMS House of Delegates, 11/15/08
Reaffirmed MMS House of Delegates, 5/2/15

Smokeless Tobacco
The Massachusetts Medical Society declares that snuff dipping and tobacco chewing are hazardous to health, and are certainly not safe alternatives to smoking.

The MMS urges physicians to make every effort to discourage the use of smokeless tobacco.

MMS Council, 2/13/85
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Government Initiatives: Sale of Tobacco Products, Advertising, Prevention
The MMS shall propose legislation to prohibit the sale of tobacco products to persons under age 21. *(D)*

MMS House of Delegates, 12/6/14

The Massachusetts Medical Society strongly supports comprehensive prevention, education, cessation, and advocacy efforts to prevent morbidity and mortality associated with tobacco use. *(HP)*

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

The Massachusetts Medical Society supports governmental initiatives, including full state funding of efforts of the Massachusetts anti-tobacco education campaign and the proposed FDA regulations on tobacco products that are designed to reduce access to tobacco products by persons under age 21. *(HP)*

The Massachusetts Medical Society encourages the state and federal government to ban all tobacco advertising directed toward or attractive to children. *(HP)*

The Massachusetts Medical Society encourages the state and federal government to eliminate cigarette sales from vending machines and free standing displays. *(HP)*

The Massachusetts Medical Society encourages the state and federal government to disallow sampling of tobacco products and of promotional items. *(HP)*

The Massachusetts Medical Society encourages the state government to impose strict penalties for the sale of tobacco products to persons under age 21. *(HP)*

The Massachusetts Medical Society urges the American Medical Association to encourage the state and federal government to support initiatives to reduce access to tobacco products by children and adolescents. *(HP)*

MMS House of Delegates, 11/17/95
Reaffirmed MMS House of Delegates, 5/31/02
Reaffirmed MMS House of Delegates, 5/8/09
Items 1 and 5 Amended and Reaffirmed MMS House of Delegates, 12/6/14
Items 2-4 and 6 Amended and Reaffirmed MMS House of Delegates 5/7/16

The Massachusetts Medical Society encourages physicians to become alert to the tobacco product advertisement in the magazines in their waiting rooms, and, that physicians be encouraged to remove magazines containing tobacco product advertisements and/or to prominently notify patients of their disapproval of these pro-smoking messages.

MMS Council, 2/10/88
Reaffirmed MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Reaffirmed MMS House of Delegates, 5/11/13

Government Initiatives: Public Areas
The MMS will advocate for and support state legislation to prohibit smoking at outdoor, pedestrian-only marketplaces. *(D)*

MMS House of Delegates, 12/5/15

The MMS supports state legislation to prohibit smoking in or near entrances and exits of buildings, especially those where large groups of smokers might gather, including but not limited to health care facilities, government buildings, educational institutions, shopping malls, movie theaters, indoor stadiums, and large department stores. *(D)*

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

The Massachusetts Medical Society urges the Massachusetts Congressional delegation to support legislative efforts to authorize Federal Drug Administration regulation of nicotine.

MMS House of Delegates, 5/11/01
Amended and Reaffirmed MMS House of Delegates, 5/9/08

Tobacco Industry
The Massachusetts Medical Society shall not undertake joint business ventures with tobacco companies or the tobacco industry or with business entities which provide significant professional representation or services to tobacco companies or the tobacco industry.

MMS House of Delegates, 5/3/96
Reaffirmed, MMS House of Delegates, 5/2/03
Reaffirmed, MMS House of Delegates, 5/14/10

Tobacco Settlement Funds
The Massachusetts Medical Society (MMS) supports using a substantial portion of the multi-state tobacco Master Settlement funds for the purposes of preventing tobacco use by children and adolescents, educating the public about the health risks of tobacco use, and encouraging and assisting adult and youth smokers to quit.

The MMS opposes use of the Master Settlement funds for purposes unrelated to health or for replacement of funding of existing programs.

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

VIOLENCE

The Massachusetts Medical Society (MMS) will continue to encourage all physicians to include screening for violence as part of their normal evaluation and prevention activities with patients.

MMS House of Delegates, 5/2/03
Reaffirmed MMS House of Delegates, 5/14/10
(Items 2 and 3 of Original: Sunset)

Interpersonal Violence
The Massachusetts Medical Society (MMS) condemns the use of all forms of violence, including force, intimidation, and coercion.

The MMS reaffirms its commitment to addressing and preventing interpersonal, and especially familial, violence.

The MMS reaffirms its commitment to improving and expanding opportunities to obtain help before resorting to violence.

The MMS reaffirms its commitment to supporting efforts to decrease the availability of weapons used for interpersonal violence.
(HP)

MMS House of Delegates, 5/7/99
Reaffirmed MMS House of Delegates, 5/12/06
Amended and Reaffirmed MMS House of Delegates, 5/17/14

Hate Crimes
The Massachusetts Medical Society recognizes the significant negative health outcomes and health care disparities caused by discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

The Massachusetts Medical Society strongly supports legal protections against discrimination and hate violence against transgender individuals based on their gender identity and expression. *(HP)*

MMS House of Delegates, 5/21/11

The Massachusetts Medical Society (MMS) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the Commonwealth of Massachusetts and the Nation as a whole.

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12

Human Trafficking
Understanding that health care providers have a unique and potentially critical role to play in the prevention, identification, treatment, and assistance of trafficked persons, the Massachusetts Medical Society:

- Affirms that human trafficking, in all its forms, is a detriment to the health and well-being of individuals, families, communities, and to society-at-large;
- Calls for the integration of human trafficking education into the curricula of medical schools;
- Supports the efforts of colleagues from other health professions to integrate human trafficking education into their respective school curricula;
- Promotes continuing medical education and training on human trafficking for all health care providers, including training on trauma-informed, survivor-centered patient care;
- Supports interprofessional and interdisciplinary efforts to prevent human trafficking and to assist trafficked persons;
- Encourages research that advances our epidemiological understanding of human trafficking, its effects on individual and population health, best practices for human trafficking prevention, education and training of health care professionals, and clinical assessment and response to trafficked persons; and
- Promotes and supports the development and implementation of evidence-based practice setting-specific response protocols, as well as broader policies, procedures, and resource allocation to assist trafficked persons who present for care in the health care setting.

(HP)

MMS House of Delegates, 5/7/16

Political and Institutional Violence
In recognition of the increasing frequency of political and institutional violence involving attacks on individuals and assemblages of men, women, and children; mass casualty events; and the intergenerational toll on physical and mental health taken by such devastating acts of violence, the MMS calls for:

- Continued research that critically examines the epidemiology and root causes of political and institutional violence;
- Support for evaluative research to assess the effectiveness of interventions and containment strategies;
- Communication and implementation of effective interventions and containment strategies;
- Responses that promote peaceful dialogue within communities; and
- Clinicians' meaningful engagement with individuals, communities, institutions, and agencies to prevent further violence and reduce suffering by dialogue and other means that help all develop healthy alternative options to expressions of hate, anger, cruelty, deindividuation, and dehumanization.

(HP)

MMS House of Delegates, 5/7/16

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

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

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

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 1of 3: Amended and Reaffirmed MMS House of Delegates, 5/17/14

Violence Against Health Care Workers
The MMS deplores all forms of violence and terrorism against all members of society, and against the physicians and health care workers who provide them with medical services.

MMS House of Delegates, 11/7/98
Reaffirmed MMS House of Delegates, 5/13/05
Reaffirmed MMS House of Delegates, 5/19/12

The Massachusetts Medical Society supports the establishment of child abuse and domestic violence detection educational programs for physicians, physicians in training and medical students. In addition, the Massachusetts Medical Society strongly encourages and facilitates the participation of physicians, physicians in training and medical students in these programs. It is further recommended that physicians be allowed to use their participation in these programs toward the risk management requirement for relicensure.

MMS House of Delegates, 5/20/94
Reaffirmed MMS House of Delegates, 5/21/11

War/Nuclear War
The MMS opposes the targeting of physicians and health care providers for killing, torture or capture, and treatment of them as combatants or conspirators, based upon their provision of medical care**.** *(HP)*

MMS House of Delegates, 5/11/13

The MMS adopts policy that:

- Advises the government of the United States, and all national governments, that even a limited nuclear war would have catastrophic effects on the world's food supply and would put a significant proportion of the world's population at risk from a nuclear famine;
- Urges education of physicians and the general public that the threat of a limited nuclear war is an overwhelming threat to public health; and
- Urges the government of the United States, and all national governments, to continue to work to ban the development, testing, production, stockpiling, transfer, deployment, threat and use of nuclear weapons. *(HP)*

MMS House of Delegates, 5/2/15

Youth Violence
The Massachusetts Medical Society (MMS) affirms its commitment to addressing and preventing all forms of violence affecting children and youth as part of its ongoing campaign against violence.

The MMS advocates for local, state, and federal legislative and regulatory policy which supports efforts to reduce the burden of physical and psychological injury caused by violence against children and youth.

The MMS supports the development and delivery of educational programs and resources for health professionals pertaining to children and youth violence.

The MMS supports the development and distribution of patient education and public awareness materials pertaining to children and youth violence, including, but not limited to all forms of entertainment and social media.

The MMS strongly encourages and facilitates the participation of physicians, physicians-in-training, medical students, and other health care professionals in educational initiatives pertaining to children and youth violence.

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

CORRECTED, COMPENDIUM ADDENDUM (THROUGH I-15)

MMS POLICY COMPENDIUM

Addendum

A) Time-Limited, Time-Specific Directives B) Directives to Sunset Upon Completion C) MMS Awards and Honors

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At A-04, the House of Delegates (HOD) adopted the following amendment to the *Procedures of the House of Delegates,* Procedure 18, Sunset Policy:

• • •

Directives adopted by the House which contain time-limited specifics; establish task forces, committees, or other special ad hoc entities; and directives to amend the Procedures of the House of Delegates or the Bylaws shall not be subject to the seven-year sunset mechanism and shall sunset automatically at the completion of the directive or document update.

Per Bylaw 6.01, adopted at A-03, the HOD approves two general types of policy: directives and health policies. The HOD began designating these two types of policy at I-03.

At I-15, the HOD adopted BOT Report I-15 C-2, Recognition Awards, which states in part that "The Board of Trustees and its Committee on Recognition Awards shall be responsible for oversight and approval of new and existing MMS recognition awards." For tracking purposes, Appendix C outlines all MMS awards and the schedule for BOT review of each award.

The following information is divided into three appendices and is intended to inform members of the following:

- **APPENDIX A: Time-Limited, Time-Specific Directives Completed/Sunset**
  Directives adopted at I-15 that are time-limited, have been completed, and have sunset.

- **APPENDIX B: Directives to Sunset Upon Completion**
  Topic areas for directives adopted at recent meetings that are due for a time-specific report back to the House of Delegates or due for implementation within a specific time, and will sunset upon completion.

- **APPENDIX C: MMS Awards and Honors**

APPENDIX A: Time-Limited/Specific Directives Completed/Sunset

	Adopted
That the Massachusetts Medical Society amend the Procedures of the House of Delegates to read as follows: 19. SUNSET POLICY A sunset mechanism with a seven-year time horizon shall exist for all Massachusetts Medical Society policy positions and statements established by the MMS House of Delegates. Each adopted resolve or recommendation within a policy shall be considered individually with regard to the sunsetting process. Under the sunset mechanism, a policy will cease to be viable unless action is taken by the House to re-establish said policy. Any action of the House that reaffirms an existing policy shall reset the sunset "clock," making the reaffirmed policy viable for seven years from the date of its reaffirmation. Any action of the House that modifies an existing policy shall reset the sunset clock, making the consolidated or modified policy viable for seven years from the date of its adoption. Directives adopted by the House which contain time-limited specifics; establish task forces, committees, or other special or ad hoc entities; and directives to amend the Procedures of the House of Delegates or the Bylaws shall not be subject to the seven-year sunset mechanism and shall sunset automatically at the completion of the directive or document update. <u>Review/Report Process</u> Policies are assigned by officers and staff to the appropriate standing committee/MMS section(s) (in consultation with appropriate special committees) to review and recommend whether to reaffirm, sunset, reaffirm for one year, or amend the policy and provide recommendations to the MMS presidential officers for final review and submission to the House of Delegates. Minor Amendments that Maintain the Original Intent of the Policy The reviewing committee may propose amendments to any policy that maintain the original intent of the policy. Such policy amendments may only be adopted or not adopted by the House of Delegates. If a proposed policy amendment is not adopted, the original policy will be reaffirmed for one year and referred to the appropriate committee(s) for further analysis and potential submission of a new policy recommendation. Such items must be reported back to the House of Delegates within one year. The reviewing committees/MMS sections and presidential officers shall prepare a single report recommending policy reaffirmation, policy sunset, policy amendment, and policy reaffirmation for one year pending submission of an updated policy for transmittal to the House on an annual basis, which shall be assigned to a single reference committee for consideration. A consent calendar format shall be used by the House in considering the policies contained in the report. <u>Policies That Require New Policy Recommendations</u> If it is determined by the reviewing committee/MMS section(s) that a policy requires a completely new policy recommendation, a new policy recommendation should be submitted for the current Annual Meeting of the House of Delegates by the resolution/report deadline. Such resolutions/reports will not be accepted as late-filed items. If the updated policy recommendation is not submitted for the current Annual Meeting, then such policy will be recommended to be reaffirmed for one year. Following House action the Board of Trustees, and/or any committee(s) designated by the Board of Trustees, will be asked to consider submitting the new policy recommendation. Upon submission and adoption of a new policy recommendation, the old policy will automatically be sunset. If the new policy recommendation is not adopted; the old policy will automatically be sunset. If new policy is referred, the	12/3/16

old policy will be maintained until report back within a one year period. If no new recommendation is adopted within one year, the policy will automatically sunset. *(D)*	
That the House of Delegates support the renewal of the following Committees (for three years, beginning FY18): Geriatric Medicine, History, Information Technology, LGBT Matters, Maternal and Perinatal Welfare, Senior Volunteer Physicians, Student Health and Sports Medicine, Violence Intervention and Prevention, and Young Physicians. (D) *ITEM A* Resolution A-15 A-101, Simplifying MMS Bylaws on Filling Vacancies for AMA Delegates *ITEM B* Resolution A-15 A-102, Simplifying the Bylaws Process for Removing AMA Delegates and Alternates Because of a Reduction in Delegation Size *ITEM C* Resolution A-15 A-103, No Longer Requiring the Presence of the Chair of the Committee on Nominations at AMA Meetings THE REPORT The Committee on Bylaws recommends that the House of Delegates approve the following amendments to the Bylaws (except as otherwise noted, added text is shown as "text" and deleted text is shown as "text"): *ITEM A* Resolution A-15 A-101, Simplifying MMS Bylaws on Filling Vacancies for AMA Delegates 9.02 Special Elections Special elections to fill vacancies (except for AMA delegates) may be conducted at any stated meeting of the House of Delegates. They shall be conducted in the following manner: • • • 9.03 Election of AMA Delegates • • • (8) A delegate to fill a vacancy which may occur during the term of an AMA delegate will be chosen by the members of the AMA delegation from among the existing AMA alternate delegates. In the event of a vacancy occurring during the term of an AMA delegate, or created by an increase in the number of delegates allocated to the Society, the Committee on Nominations, in accordance with its procedures, shall present a nominee selected from the qualified alternate delegates to the House of Delegates to fill the vacancy at the next interim or annual meeting of the House of Delegates. If the Committee on Nominations is unable to meet to nominate a candidate for election by the House of Delegates prior to the next meeting of the AMA, the Committee on Nominations shall notify the president, who shall appoint a delegate from the qualified alternate delegates. The term for the delegate appointed by the president shall expire on December 31 of the year in which the appointment occurred. In the event of a vacancy occurring during the term of an AMA alternate delegate, the Committee on Nominations, in accordance with its procedures, may present a nominee to the House of Delegates to fill the vacancy at the next interim or annual meeting of the House of Delegates. The president, in consultation with the chair and vice chair of the Committee on Nominations, shall appoint an AMA alternate delegate *ad interim* to serve until the House of Delegates shall elect a successor.	12/3/16

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ITEM B Resolution A-15 A-102, Simplifying the Bylaws Process for Removing AMA Delegates and Alternates Because of a Reduction in Delegation Size

9.03 Election of AMA Delegates

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(6) In the event that the AMA notifies the Society that the number of delegates allocated to the Society is decreased, the members of the delegation shall select a delegate to delegate who has served the least amount of time as a delegate shall become an alternate delegate and shall select two of the elected alternate delegates to the two alternate delegates who have served the least amount of time as alternate delegates shall be removed from the delegation. In the event of a tie in amount of time served, the members of the AMA delegation shall make the determination by a random process. This section shall not apply to students and residents elected for a one-year term in accordance with Bylaw section 9.03(e).

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ITEM C Resolution A-15 A-103, No Longer Requiring the Presence of the Chair of the Committee on Nominations at AMA Meetings

9.03 Election of AMA Delegates
(1) The chair of the Committee on Nominations will attend AMA meetings and will provide each year to the Committee on Nominations a status report of the activities of the members of the AMA delegation.

(D)
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<tr><td>That the MMS create a Special Committee on the Sustainability of Private Practice appointed to staggered three year terms and tasked with providing periodic feedback to the Board of Trustees and the House of Delegates on matters related to the viability and unique needs of private practice physicians in the Commonwealth of Massachusetts, for the benefit of all physicians and patients in the Commonwealth.
(D)</td><td>12/5/15</td></tr>
<tr><td>That the MMS appoint a broad-based task force to explore and develop a committed strategy for leadership development that would engage physicians from diverse backgrounds. Suggestions for improvement shall include:

1. Comparing MMS membership demographic data to available physician population data for Massachusetts
2. Identifying tactics other state or national professional organizations have used to promote diversity in leadership (D)</td><td>12/5/15</td></tr>
<tr><td>That the Board of Trustees support the renewal of the following committees: Accreditation Review, Diversity in Medicine, Environmental and Occupational Health, Men’s Health, Nutrition and Physical Activity, Oral Health, Senior Physicians, Sponsored Programs, and Women in Medicine. (D)</td><td>12/5/15</td></tr>
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That the Board of Trustees recommend to the House of Delegates adoption of the following recommendations for MMS awards:
1. The Board of Trustees and its Committee on Recognition Awards shall be responsible for oversight and approval of new and existing MMS recognition awards.

2. Committee on Recognition Awards Procedures and Criteria for New Awards
A. Sponsors of new awards are required to complete an application for approval of new awards as developed by Committee on Recognition Awards. The application for approval of new awards may include the following items:
▪ Sponsor of the award
▪ Description and significance of the award
▪ Purpose of the award
▪ Eligibility criteria (e.g. MMS members only, non-members, physicians only, etc.)
▪ Criteria/metrics for specific award (e.g. technical accomplishment, exemplary performance in their field, etc.)
▪ Describe how this award differs from existing awards
▪ Describe the process and criteria (rubric) that will be used to evaluate nominees (two endorsement letters, Committee review and selection, etc.)
▪ Describe the potential pool of nominees
▪ Describe the recognition award (e.g. plaque, monetary, etc.)
▪ Indicate the presentation venue (e.g. committee meeting, forum, Annual Meeting, etc.)
B. The Committee on Recognition Awards reviews the application and submits its recommendation in a report to the Board of Trustees for approval.
C. The Board of Trustees reports to the House of Delegates through its informational report.

3. Committee on Recognition Awards Procedures and Criteria for Existing Awards
A. The Committee on Recognition Awards reviews all awards (with the exception of the annual committee chair and the 50-year member recognition) for sunset/reaffirmation/amendment every 7 years with initial staggering dates for review.
B. Sponsors of the awards complete an application for renewal as requested by the Committee on Recognition Awards.
C. The application for renewal of existing awards may include the following items:
▪ Sponsor of the award
▪ Description and significance of the award
▪ Purpose of the award
▪ Eligibility criteria (e.g. MMS members only, non-members, physicians only, etc.)
▪ Criteria/metrics for specific award (e.g. technical accomplishment, exemplary performance in their field, etc.)
▪ Describe how this award differs from existing awards
▪ Describe the process and criteria (rubric) that will be used to evaluate nominees (two endorsement letters, Committee review and selection, etc.)
▪ Describe the potential pool of nominees
▪ Describe the recognition award (e.g. plaque, monetary, etc.)
▪ Indicate the presentation venue (e.g. committee meeting, forum, Annual Meeting, etc.)
▪ Indicate the number of applicants and name of recipient for each year.
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D. The Committee on Recognition Awards reviews the application and submits its recommendation in a report to the BOT for approval. E. The Board of Trustees reports to the House of Delegates through its informational report. *(D)*	

APPENDIX B: Directives to Sunset upon Completion

Topic Area	**Adopted**
CIVIL/HUMAN RIGHTS Nondiscrimination (DACA, Item 1)	12/3/16
ENVIRONMENTAL HEALTH Climate Change (Item 2)	12/3/16
ETHICS End-of-Life Care	12/3/16
MMS ADMINISTRATION AND MANAGEMENT Membership and Dues	5/21/11
MMS ADMINISTRATION AND MANAGEMENT Committees (Items 2-3)	12/3/16
PHYSICIANS Physician Call	12/6/14
MEDICAL EDUCATION LGBT Students and Patients	12/6/14
HEALTH CARE DELIVERY Identification Badges	5/2/15
MEDICAL RECORDS Electronic Health Records	5/2/15
MEDICAL RECORDS Electronic Health Records (Item 1 & 2)	12/5/15
HOSPITALS Hospital/Organized Medical Staff/Employed Physicians	5/2/15

	Award	**Established**	**Renewal BOT Review Schedule**	**Previously Sunset by HOD**
1.	**MMS Lifetime Achievement**	10/93	**2017**	5/00
2.	**Men's Health**	5/09	**2017**	
3.	**Community Clinician of the Year**	11/98	**2017**	5/05
4.	**Senior Volunteer Physician**	11/01 reaffirmed 5/09	**2017**	
5.	**Excellence in Medical Service**	5/95	**2018**	5/02
6.	**Information Technology in Medicine**	6/99 by BOT	**2018**	
7.	**Grant V. Rodkey, MD, Award for Outstanding Contributions to Medical Education**	1995	**2018**	
8.	**Distinguished Service to the MMS**	5/95	**2019**	5/02
9.	**Woman Physician Leadership**	5/12	**2019**	
10.	**Woman's Health**	5/12	**2019**	
11.	**Medical Student Scholars**	5/00 reaffirmed 5/07 amended & reaffirmed 5/19/12	**2019**	

12.	**Henry Ingersoll Bowditch Award for Excellence in Public Health**	5/96	**2020**	5/03
13.	**LGBT Health**	5/13	**2020**	
14.	**Woman's Health Research**	5/13	**2020**	
15.	**Oliver Wendell Holmes, MD, Stethoscope**	11/99 11/06 5/13	**2020**	
16.	**Reducing Health Disparities**	5/14	**2021**	
17.	**Medical Student History Essay Contest**	5/07 amended & reaffirmed 5/14	**2021**	