

Reference Committee on Amendments to Constitution and Bylaws

YPS HOD Handbook Review Committee: Basem Abdelmalak, MD, Chair; Brad Butler, MD; Ravi Goel, MD

Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18585.html>.

HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD Action
BOT Report 2: Pharmacists' Refusal to Fill Legally Valid Prescriptions	<p>The Board of Trustees recommends that the following be adopted and the remainder of this report be filed:</p> <p>That our American Medical Association reaffirm Policy H-120.947, "Preserving Patients' Ability to Have Legally Valid Prescriptions Filled." (Reaffirm HOD Policy)</p> <p>Fiscal Impact: None</p>	Monitor	Adopted as amended by addition of a second recommendation. See http://www.ama-assn.org/ama1/pub/uploadd/mm/471/refcomccb.doc for exact wording.
BOT Report 13: Ethical Procurement of Organs for Transplantation	<p>The Board of Trustees recommends that the following statement be adopted in lieu of Resolution 8 (A-07) and the remainder of the report be filed:</p> <p>That our American Medical Association continue to monitor ethical issues related to organ transplantation and develop additional policy as necessary. (Directive to Take Action)</p> <p>Fiscal Note: Estimated staff cost of less than \$500.</p>	Support	Adopted
BOT Report 20: Protection of Medical Staff Members' Personal Proprietary Financial Information	<p>The Board of Trustees recommends that the following statements be adopted and the remainder of the report be filed:</p> <p>1. That AMA policy be that hospitals/health systems consider incorporation, as appropriate, of the following guidelines in the development and implementation of their "conflict of interest" programs: (New HOD Policy)</p> <p>(a) Physicians should be required to disclose certain personal proprietary financial information to the hospital/health system only if they are serving or being considered to serve on the hospital governing body or in an elected or appointed leadership position (e.g., the chair of a department or division, etc.).</p> <p>(b) The regular members of the medical staff who do not have officer or other leadership positions should not be required to divulge any of their personal proprietary financial information, as they are not fiduciaries to the hospital. The disclosure of personal proprietary financial information should not be a requirement for medical staff membership or privileges.</p> <p>(c) The personal proprietary financial information requested and required of medical staff members who currently serve or are being considered for a position on the hospital governing body should be no greater than that requested and required of the non-physician members of the hospital governing body.</p>	Support	Referred

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	<p>(d) These medical staff members serving or being considered to serve on the hospital governing body or in an elected or appointed leadership position (e.g., the chair of a department or division, etc.) may be required to disclose no more than the following “material” and personal interests under “conflict of interest” programs: 1) Employment, consulting or other financial arrangement with another hospital; 2) An ownership interest of at least 5% in another hospital, excluding a physician’s individual or group practice (exact percentage ownership interest should not be required to be disclosed); 3) An ownership interest of at least 5% in an organization providing products or services to the hospital or another hospital (including a financial interest in an entity which is engaged in a substantive existing or proposed business relationship with the hospital); 4) Receipt of more than 5% of his/her annual income from the conflicted financial interest (exact percentage should not be required to be disclosed); 5) Holding the position of director, trustee, officer or key employee in another hospital, excluding a physician’s individual or group practice, or an organization providing substantive products or services to the hospital or another hospital (including an entity which is engaged in an existing or proposed business relationship with the hospital); and 6) Any relevant personal interests (e.g., pursuit by the affected individual of a claim or litigation against the hospital).</p> <p>(e) The fact that there may be a conflict of interest should not, by itself, be grounds for exclusion from office or a board position.</p> <p>(f) If a position on the governing body is declined or withheld based solely on personal proprietary financial information, or lack thereof, that member of the medical staff should be given the option to appeal via a defined “due process,” should s/he so choose.</p> <p>(g) Any information disclosed as part of a hospital/health system “conflict of interest” program, particularly personal financial information in the limited circumstances in which it is relevant, should be kept confidential and limited to the issues of election or appointment to a leadership position, and determining whether recusal from voting or discussion on an issue may be appropriate.</p> <p>2. That AMA policy be that medical staff members’ personal proprietary financial information shall remain confidential except for disclosure to those with a bona fide need to access such information, such as for conflict of interest purposes in connection with their leadership position. The security and storage of such information, including electronic and paper-based, should be at the same level as that afforded to other data and files in the hospital, such as patient and peer review information, that enjoy confidentiality and privacy protections, including restricted access, password protection and other protective mechanisms.</p>		

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	<p>(New HOD Policy)</p> <p>Fiscal Note: Staff cost estimated to be less than \$500 to implement.</p>		
<p>CC&B Report 1: Editorial Corrections to AMA Bylaws</p>	<p>The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted by the House of Delegates and that the remainder of this report be filed.</p> <p>2.00 House of Delegates</p> <p>2.12 National Medical Specialty Societies. Each national medical specialty society granted representation in the House of Delegates is entitled to delegate representation based on the number of seats allocated to it by apportionment, and such additional delegate seat as may be provided under Bylaw 2.122.</p> <p>2.121 Apportionment. The apportionment of delegates from each specialty society represented in the AMA House of Delegates is one delegate for each 1,000, or fraction thereof, physician members or fourth year medical student members of the AMA who select that specialty society to represent the member or who are allocated to that specialty society by extrapolation methods specified in AMA policy. Notwithstanding the foregoing requirements, the apportionment of delegates and alternate delegates in effect for 2003 from each specialty society represented in the AMA House of Delegates in 2003 shall remain in effect until December 31, 2007. The delegates eligible for seating in the House of Delegates by apportionment are in addition to the additional delegate and alternate delegate authorized for unified specialty societies meeting the requirements of Bylaw 2.122.</p> <p>2.1211 Phase-in (2008-2011) Following End of Apportionment Freeze. If the specialty society selection information as recorded by the AMA as of December 31, 2007 warrants a decrease in the number of delegates representing a specialty society, the specialty society shall be permitted to retain the same number of delegates, without decrease during 2008, if it promptly files with the AMA a written plan of intensified AMA membership development activities among its members. Commencing January 1, 2009, a phase-in period will be implemented such that the number of delegate seats lost by a specialty society will be limited to one seat per year during 2009-2011. On January 1, 2012, any remaining reduction of seats will be implemented, based on December 31, 2011 membership numbers. This Bylaw will sunset on January 2, 2012.</p> <p>3.00—Officers</p>	<p>Support/Monitor</p>	<p>Adopted</p>

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	<p>3.50 Terms and Tenure.</p> <p>3.58 Public Trustee. Prior to 2007, the public trustee shall be elected for a term of 2 years, and shall not serve for more than 3 terms. A public trustee elected in 2007 and thereafter shall be elected for a term of 4 years, and shall not serve for more than one term. A public trustee shall have all of the rights of a trustee to participate fully in meetings of the Board, including the right to make motions and to vote on policy issues, except that a public trustee shall not have the right to vote on intra-Board elections. A public trustee shall not be eligible for election as an officer of the Board of Trustees.</p> <p>3.581 Limit on Total Tenure. The public trustee elected prior to 2007 shall be limited to a maximum tenure of 6 years. A public trustee elected in 2007 and thereafter shall be limited to a maximum tenure of 4 years.</p>		
<p>CEJA Report 1: Industry Support of Professional Education in Medicine</p>	<p>The Council on Ethical and Judicial Affairs recommends that the following be adopted and that the remainder of this report be filed:</p> <p>Medicine's autonomy and authority to regulate itself depends on its ability to ensure that current and future generations of physicians acquire, maintain, and apply the values, knowledge, skills, and judgment essential for quality patient care. To fulfill this obligation, medicine must ensure that the values and core commitments of the profession protect the integrity of professional education. It must strive to deliver scientifically objective and clinically relevant information to individuals across the learning continuum—from medical school, into residency and fellowship training, and throughout continuing medical education.</p> <p>To promote continued innovation and improvement in patient care, medicine must sustain ongoing, productive relationships with the pharmaceutical, biotechnology, and medical device companies. However, industry support of professional education has raised concerns that threaten the integrity of medicine's educational function. Existing mechanisms to manage potential conflicts and influences are not sufficient to address these concerns.</p> <p>Given medicine's current reliance on industry funding of professional education, implementing the following recommendations will take time. Yet we must recognize the profession-defining importance of ultimately achieving these goals. To that end:</p>	<p>Active Oppose</p>	<p>Referred</p>

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	<p>(1) Individual physicians and institutions of medicine, such as medical schools, teaching hospitals, and professional organizations (including state and medical specialty societies) must not accept industry funding to support professional education activities. Examples of such activities include, but are not limited to, industry funding for:</p> <ul style="list-style-type: none"> (a) residency positions and clinical fellowships; (b) didactic educational programs, such as live or web-based continuing medical education activities; (c) physician speakers' bureaus; and (d) travel, lodging, and amenities for participants of clinically relevant educational programming. <p>(2) One exception to no industry support of professional education is when new diagnostic or therapeutic devices and techniques are introduced. Given the requirement for technical training on how to use new devices, industry representatives may have to play an educational role because they could be the only available teachers. But once expertise in the use of previously new devices has developed within the professional community, continuing industry involvement in educating practitioners is no longer warranted. Technical assistance or support that industry representatives may provide physicians in the context of patient care (e.g., helping a surgeon in the operating room select the appropriately sized prosthesis components) is not considered professional education and is not ethically inappropriate.</p> <p>(3) Medical schools and teaching hospitals are learning environments for future physicians at a critical, formative phase in their careers. These institutions have special responsibilities to create and foster learning and work environments that instill professional values, norms, and expectations. They must limit, to the greatest extent possible, industry marketing and promotional activities on their campuses. Examples of such activities include, but are not limited to:</p> <ul style="list-style-type: none"> (a) free food and other industry gifts for trainees and faculty, and (b) detailing visits by industry representatives. <p>Medical schools and teaching hospitals have a further responsibility to educate trainees about how to interact with industry and their representatives, especially if and when trainees</p>		

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	<p>choose to engage industry in varying capacities after residency and fellowship training.</p> <p>(4) The medical profession must work together to:</p> <p>(a) identify the most effective modes of instruction and evaluation for physician learners, then;</p> <p>(b) more efficiently develop and disseminate educational programming that serves the educational needs of all physicians, especially for those who have difficulty accessing continuing medical education (such as those who practice in rural areas); and</p> <p>(c) obtain more noncommercial funding of professional education activities.</p> <p>(New HOD/CEJA Policy) Fiscal Note: Staff cost estimated at less than \$500 to implement</p>		
<p>CEJA Report 3: Secret Shopper "Patients"</p>	<p>The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:</p> <p>Physicians have an ethical responsibility to engage in activities that contribute to continual improvements in patient care. One method for promoting such quality improvement is through the use of secret shopper "patients" who have been appropriately trained to provide feedback about physician performance in the clinical setting. A sound secret shopper program should include the following elements:</p> <p>(1) All relevant parties, especially those to whom secret shoppers will be making unannounced visits, should be notified that this mechanism is being implemented in their practice setting.</p> <p>(2) The information collected by secret shoppers should be used only to identify areas of improvement and not as a basis for punitive actions. Third parties should not have access to information collected by secret shoppers that includes personally identifying data.</p> <p>(3) Feedback from secret shopper "patients" should not be relied on as the sole source of data for evaluating clinical performance.</p> <p>(4) The use of secret shopper "patients" should not be implemented in a manner that adversely affects access to medical care by legitimate patients. For example, the need for urgent care (such as in the emergency department setting) must always take precedence over secret shopper "patients."</p>	<p>Active Oppose</p>	<p>Referred</p>

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	<p>(New HOD/CEJA Policy) Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>		
<p>CEJA Report 4: Peers as Patients</p>	<p>The Council on Ethical and Judicial Affairs recommends that the following be adopted, in lieu of Resolution 1 (A-07), and that the remainder of this report be filed.</p> <p>The opportunity to care for a fellow physician is a privilege and may represent a gratifying experience and serve as a show of respect or competence. In emergencies or isolated or rural settings when options for care by other physicians are limited or where there is no other qualified physician available, physicians should not hesitate to treat peers. There are, however, a number of ethical considerations to weigh before undertaking the care of a colleague.</p> <p>(1) Physicians who provide care to a peer should be alerted to the possibility that their professional relationship with the patient may affect their ability to exercise objective professional judgment and make unbiased treatment recommendations. They must also recognize that the physician-patient may be reluctant to disclose sensitive information or permit an intimate examination.</p> <p>(2) Physicians providing care to a professional colleague have an obligation to respect informational and physical privacy of physician-patients as they would for any patient. Treating physicians should consider, and possibly discuss with the physician-patient, how to respond appropriately to the inquiries about the physician-patient's medical care from other physicians or medical staff. Treating physicians should also recognize that special measures may be required to ensure that the physician-patient's physical privacy is respected.</p> <p>(3) Physicians providing care to a colleague should respect the physician-patient's right to participate in informed decision making. Treating physicians should make no assumptions about the physician-patient's knowledge about her or his medical condition and should provide information to enable the physician-patient to make voluntary, fully informed decisions about care.</p> <p>(4) Physicians in training and medical students face unique challenges when asked to provide or participate in care for peers given the circumstances of their roles in medical schools and residency programs. Except in emergency situations or when other care is not available, physicians in training should not be required to care for fellow trainees, faculty members, or attending physicians if they are reluctant to do so.</p>	<p>Support/Monitor</p>	<p>Adopted</p>

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	<p>(New HOD/CEJA Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>		
<p>CEJA Report 5: Sedation to Unconsciousness in End-of-Life Care</p>	<p>The Council on Ethical and Judicial Affairs recommends that the following be adopted and that the remainder of this report be filed.</p> <p>The duty to relieve pain and suffering is central to the physician’s role as healer and is an obligation physicians have to their patients. Palliative sedation to unconsciousness is the administration of sedative medication to the point of unconsciousness in a terminally ill patient. It is an intervention of last resort to reduce severe, refractory pain or other distressing clinical symptoms that do not respond to aggressive symptom-specific palliation. It is an accepted and appropriate component of end-of-life care under specific, relatively rare circumstances. When symptoms cannot be diminished through all other means of palliation, including symptom-specific treatments, it is the ethical obligation of a physician to offer palliative sedation to unconsciousness as an option for the relief of intractable symptoms. When considering the use of palliative sedation, the following ethical guidelines are recommended:</p> <ol style="list-style-type: none"> (1) Patients may be offered palliative sedation when they are in the final stages of terminal illness. The rationale for all palliative care measures should be documented in the medical record. (2) Palliative sedation to unconsciousness may be considered for those terminally ill patients whose clinical symptoms have been unresponsive to aggressive, symptom-specific treatments. (3) Physicians should ensure that the patient and/or the patient’s surrogate have given informed consent for palliative sedation to unconsciousness. (4) Physicians should consult with a multidisciplinary team, including an expert in the field of palliative care, to ensure that symptom-specific treatments have been sufficiently employed and that palliative sedation to unconsciousness is now the most appropriate course of treatment. (5) Physicians should discuss with their patients considering palliative sedation the care plan relative to degree and length (intermittent or constant) of sedation, and the specific expectations for continuing, withdrawing or withholding future life-sustaining treatments. 	<p>Monitor</p>	<p>Adopted with editorial changes offered by CEJA. See http://www.ama-assn.org/ama1/pub/uploadd/mm/471/refcomccb.doc for exact wording.</p>

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	<p>(6) Once palliative sedation is begun, a process must be implemented to monitor for appropriate care.</p> <p>(7) Palliative sedation is not an appropriate response to suffering that is primarily existential, defined as the experience of agony and distress that may arise from such issues as death anxiety, isolation and loss of control. Existential suffering is better addressed by other interventions. For example, palliative sedation is not the way to address suffering created by social isolation and loneliness; such suffering should be addressed by providing the patient with needed social support.</p> <p>(8) Palliative sedation must never be used to intentionally cause a patient's death.</p> <p>(New HOD/CEJA Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement</p>		
<p>CEJA Report 6: Expedited Partner Therapy</p>	<p>The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:</p> <p>Expedited Partner Therapy (EPT) is the practice of treating the sex partners of patients with sexually transmitted diseases via patient-delivered partner therapy without the partner receiving a medical evaluation or professional prevention counseling. While this practice is presently recommended by the Centers for Disease Control and Prevention for use in very limited circumstances (for gonorrhea or chlamydial infection in heterosexual men and women), EPT may be recommended for additional applications in the future.</p> <p>Although EPT has been demonstrated to be effective at reducing the burden of certain diseases, it also has ethical implications. EPT potentially abrogates the standard informed consent process, compromises continuity of care for patients' partners, encroaches upon the privacy of patients and their partners, increases the possibility of harm by a medical or allergic reaction, leaves other diseases or complications undiagnosed, and may violate state practice laws. The following guidelines are offered for use in establishing whether EPT is appropriate:</p> <p>(1) Physicians should determine the need for EPT by engaging in open discussions with patients to ascertain their partners' abilities to access medical services. Only if the physician reasonably believes that a patient's partner(s) will be unwilling or unable to seek treatment within the context of a traditional patient-physician relationship should the use of EPT be</p>	<p>Monitor/Oppose</p>	<p>Adopted</p>

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	<p>considered.</p> <p>(2) Prior to initiating EPT, physicians are advised to seek the guidance of public health officials, as well as determine the legal status of EPT in their state.</p> <p>(3) If the physician chooses to initiate EPT, he or she must provide patients with appropriate instructions regarding EPT and its accompanying medications and answers to any questions that they may have.</p> <p>(4) Physicians must provide patients with educational material to share with their partners that encourages the partners to consult a physician as a preferred alternative to EPT, and that discloses the risk of potential adverse drug reactions and the possibility of dangerous interactions between the patient-delivered therapy and other medications that the partner may be taking. The partner should also be informed that he or she may be affected by other STDs that may be left untreated by the delivered medicine.</p> <p>(5) The treating physician should also make reasonable efforts to refer a patient's partner(s) to appropriate health care professionals.</p> <p>(New HOD/CEJA Policy)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement</p>		
<p>CEJA Report 11: CEJA's Sunset Review of House Policies</p>	<p>The Council on Ethical and Judicial Affairs recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of this report be filed. (Directive to Take Action.)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	<p>Support/Monitor</p>	<p>Adopted</p>

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Resolution 1: Pharmaceutical Grants and Gifts to Physicians	<p>RESOLVED, That our American Medical Association support federal policy seeking mandatory disclosure of financial relationships between physicians and pharmaceutical interests, with the exception of samples intended for provision to patients and meals in conjunction with educational meetings (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA support policy that would require pharmaceutical companies and makers of medical devices to report all payments (such as cash, grants, contracts), gifts, honoraria or other emoluments (travel, entertainment, sports or recreation, lodging) given to physicians and others with a value over \$100, and that all such reports be made public at least annually. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$4,800.</p>	Monitor	Not adopted
Resolution 2: Promoting Representative Equality at the MSS Business Meeting	<p>RESOLVED, That our American Medical Association Bylaws be amended to reflect the following Medical Student Section Business Meeting representation criteria for central and satellite campuses:</p> <ol style="list-style-type: none"> 1. The AMA medical student members of each educational program as defined in Bylaw 7.331 that has more than one campus may select one representative and one alternate representative from each campus. 2. Each central campus that has a total student population (not including students at any associated satellite campuses) greater than 999 may select one additional representative and one additional alternate representative. 3. A satellite campus is redefined as a separate administrative campus from the central campus where a minimum of 20 members of the medical school student body are assigned for some portion of instruction over a period of time not less than one academic year (and that specific reference in AMA Bylaws to the Charles R. Drew University of Medicine and Science is no longer necessary because that campus qualifies for representation under the proposed definition of a satellite campus). (Modify Bylaws) <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	Monitor/Support	Adopted

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Resolution 3: Studying the Ethical Implications of Creating Cytoplasmic Human-Animal Hybrids	<p>RESOLVED, That our American Medical Association study the ethical implications of creating “cytoplasmic” human-animal hybrids. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$3,050.</p>	Monitor	Referred
Resolution 4: Futile Care	<p>RESOLVED, That our American Medical Association create a Task Force representative of the various stakeholders, for example, the AMA, American Osteopathic Association, American Hospital Association, AARP, and religious and ethical leaders, to evaluate the issues related to the appropriateness of end-of-life care. (Directive to Take Action)</p> <p>Fiscal Note: Estimated cost of \$24,805 includes creation of a task force of stakeholders to evaluate issues related to the appropriateness of end of life care. This includes meetings and policy development.</p>	Monitor	Referred
Resolution 5: Employment Relations	<p>RESOLVED, That our American Medical Association Council on Ethical and Judicial Affairs render an opinion on the ethical implications of permitting physicians to be employees of those the physician is charged with supervising. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$3,051.</p>	Monitor/support	Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/refcomccb.doc for exact wording.
Resolution 6: End of Life and "Allow Natural Death"	<p>RESOLVED, That our American Medical Association study alternatives to Do Not Resuscitate (DNR) by working with state medical societies and other major stakeholders, to conduct a comprehensive review and study of all state Advance Directives to determine whether the state DNR systems and forms should be changed to AND (Allow Natural Death), LET (Limits of Emergency Treatment), POLST (Physician Orders for Life-Sustaining Treatment) or some other alternative systems. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$8,300.</p>	Monitor	Adopted

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<p>Resolution 7: Enhancing the Voice of the Minority Affairs Consortium</p>	<p>RESOLVED, That our American Medical Association establish the Minority Affairs Consortium as a section (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA modify Policy D-615.989 by deleting the second clause and inserting “establish the Minority Affairs Consortium as a section advocating in conjunction with the AMA on minority health and professional health issues of underrepresented minority physicians” (Modify Current HOD Policy); and be it further,</p> <p>RESOLVED, That our AMA approve a name change from the Minority Affairs Consortium to the Minority Affairs Section and be recognized as such in the AMA Bylaws (Directive to Take Action); and be it further</p> <p>RESOLVED, That our AMA authorize the MAC to develop a mechanism for automatically enrolling AMA members from racial and ethnic groups underrepresented in medicine as MAC members while continuing to have an opt-in enrollment process for physicians not considered a part of this underrepresented population. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated staff cost of \$750.</p>	<p>Monitor</p>	<p>Referred</p>
<p>Resolution 8: Expanding Minority Voices in the AMA Resident and Fellow Section</p>	<p>RESOLVED, That our American Medical Association revise its bylaws to allow seating of a delegate to the AMA Resident and Fellow Section assembly for one representative from each national minority medical organization, including but not limited to the National Medical Association, the National Hispanic Medical Association, and the Association of American Indian Physicians. (Modify Bylaws)</p> <p>Fiscal Note: Staff cost estimated at less than \$500 to implement.</p>	<p>Monitor/Support</p>	<p>Withdrawn</p>
<p>Resolution 9: Security Breaches in Electronic Medical Records</p>	<p>RESOLVED, That our American Medical Association study whether a physician has a duty to inform a patient if he/she has reason to believe that the patient’s protected health information has been disclosed. (Directive to Take Action)</p> <p>Fiscal Note: Implement accordingly at estimated cost of \$24,500.</p>	<p>Support/Monitor</p>	<p>Adopted as amended; see http://www.ama-assn.org/ama1/pub/uploadd/mm/471/refcomccb.doc for exact wording.</p>

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Note: The text of all resolutions and reports can be viewed at <http://www.ama-assn.org/ama/pub/category/18585.html>.

HOD resolution/report	Action requested	Recommended AMA-YPS position	Final AMA-HOD Action
Resolution 10: Pilot Studies on Financial Incentives for Organ Donation	RESOLVED, That our American Medical Association place high on its legislative agenda modification of the National Organ Transplantation Act to rescind prohibition of “valuable consideration” for organ donation, so that pilot studies of financial incentives for donation can be carried out. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$8,928.	Monitor	Adopted as amended with change in title. See http://www.ama-assn.org/ama1/pub/upload/mm/471/refcomccb.doc for exact wording.
Resolution 11: AMA President's Medallion	RESOLVED, That our American Medical Association Council on Constitution and Bylaws prepare an amendment to the AMA Bylaws to codify the authority of the AMA president to give a President’s Medallion to a person or President’s Citation to an organization for outstanding service in promoting the art and science of medicine and the betterment of public health. (Modify Bylaws) Fiscal Note: Staff cost estimated at less than \$500 to implement change in Bylaws. Costs for awards, including medallion and travel for recipient, range from \$1000 to \$10,000 per award, depending on allowances (e.g., reception, hotel nights and spousal travel).	Monitor/Support	Referred for decision
Resolution 12: Medical Ethical Guidelines for Informed Consent in Investigational Trials	RESOLVED, That our American Medical Association request our Council on Ethical and Judicial Affairs review the physician investigator’s obligation to inform patients of potential conflicts of interest in recommending patients for or the conduct of a proposed research study. (Directive to Take Action) Fiscal Note: Implement accordingly at estimated staff cost of \$3,700.	Monitor/Support	Adopted
Resolution 13: Physician Employment by a Physician Extender	RESOLVED, That our American Medical Association define the ethical boundaries applicable to physicians supervising or collaborating with physician extenders while concurrently employed by the physician extender. (Directive to Take Action) Fiscal Note: Estimated staff cost of \$4,763 to prepare CEJA report.	Monitor/Support	Adopted