RESOLUTION 02-21

Title: Vision Qualifications for Driver's License

Introduced by: Patrick J. Droste, MD, for the Michigan Society of Eye Physicians & Surgeons

Original Author: Patrick J. Droste, MD

Referred To:

House Action:

Whereas, current vision qualifications for operating motor vehicles were derived by various states in the 1920s and 1930s, and

Whereas, the American Medical Association (2003) in its Physician's Guide to Assessing and Counseling Older Drivers stated, "Although many states currently require far visual acuity of 20/40 for an unrestricted license, current research indicates that there is no scientific basis for this cut-off. In fact, studies undertaken in some states have demonstrated that there is no increased crash risk between 20/40 and 20/70 resulting in several new state requirements," and

Whereas, good data exists to recommend reconsideration of visual acuity standards in many states, and

Whereas, it has been well known that some persons with reduced acuity continue to drive safely, and

Whereas, persons with significant visual field defects that violate state licensure requirements can be taught to drive safely, and

Whereas, tests for cognitive well-being are generally not used in motor vehicle licensure testing protocols in most states, and

Whereas, denying drivers licensure without evidence to support that denial frequently causes isolation, depression, and increased expenses for ill-advised and unnecessary medical visits, and

Whereas, crash avoidance systems, unimagined one century ago, are routinely incorporated in automotive and roadway systems, and

Whereas, autonomous vehicle technology is in advanced stages of development and has been supported by MSMS, the AMA, and the National Highway Traffic and Safety Administration (NHTSA), and

Whereas, it is well known that a large proportion of mortality involved auto crashes are accompanied by "driver error," and

Whereas, studies have been performed that show that drivers with the visual acuity less than 20/50 can be safe and competent drivers, and

Whereas, the Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology (AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity / visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) urge our AMA to engage with stakeholders including, but not limited to, the American Academy of Ophthalmology, National Highway Traffic Safety Commission, and interested state medical societies, to make recommendations on standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver's licensing privileges; and be it further

RESOLVED: That MSMS work with the American Medical Association (AMA) in any efforts by our AMA to seek stakeholder engagement to address standardized vision requirements and cognitive testing, when applicable, for unrestricted and restricted driver's licensing privileges. MSMS shall communicate any resulting recommendations to the Michigan Secretary of State legislative liaison, Michigan legislators serving on committees with oversight of transportation issues, and other stakeholders as appropriate.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

STATEMENT OF URGENCY: The Michigan Society of Eye Physicians and Surgeons (MiSEPS) has submitted a Council Advisory Recommendation (CAR: 21-03) to the American Academy of Ophthalmology (AAO) urging state ophthalmologic societies to approach their legislators to consider reviewing, perhaps relaxing, the visual acuity/visual field requirements for licensure while simultaneously advocating for simple appropriate tests where cognitive decline is suspected. Timing is everything. Waiting a year to introduce this resolution could be detrimental to harnessing the momentum that could put Michigan at the forefront of addressing this important national health and safety issue. Current vision qualifications for operating motor vehicles were derived with no firm scientific underpinnings by the various states in the 1920s and 1930s and are outdated. This CAR was cosponsored by 10 state and subspecialty societies showing national momentum and support for this effort. At the state level, legislation to update vision qualifications for operating motor vehicles serves the public good. It also offers a good opportunity for stronger relations, increased credibility and capacity building to be better prepared to stand up to potential threats to medically led vision care including the strong potential of a scope challenge by optometry.

Relevant MSMS Policy:
None

Relevant AMA Policy:

8.2 Impaired Drivers & Their Physicians

A variety of medical conditions can impair an individual's ability to operate a motor vehicle safely, whether a personal car or boat or a commercial vehicle, such as a bus, train, plane, or commercial vessel. Those who operate a vehicle when impaired by a medical condition pose threats to both public safety and their own well-being. Physicians have unique opportunities to assess the impact of physical and mental conditions on patients' ability to drive safely and have a responsibility to do so in light of their professional obligation to protect public health and safety. In deciding whether or how to intervene when a patient's medical condition may impair driving, physicians must balance dual responsibilities to promote the welfare and confidentiality of the individual patient, and to protect public safety.

Not all physicians are in a position to evaluate the extent or effect of a medical condition on a patient's ability to drive, particularly physicians who treat patients only on a short-term basis. Nor do all physicians necessarily have appropriate training to identify and evaluate physical or mental conditions in relation to the ability to drive. In such situations, it may be advisable to refer a potentially at-risk patient for assessment.

To serve the interests of their patients and the public, within their areas of expertise physicians should: (a) Assess at-risk patients individually for medical conditions that might adversely affect driving ability, using best professional judgment and keeping in mind that not all physical or mental impairments create an obligation to intervene. (b) Tactfully but candidly discuss driving risks with the patient and, when appropriate, the family when a medical condition may adversely affect the patient's ability to drive safely. Help the patient (and family) formulate a plan to reduce risks, including options for treatment or therapy if available, changes in driving behavior, or other adjustments. (c) Recognize that safety standards for those who operate commercial transportation are subject to governmental medical standards and may differ from standards for private licenses. (d) Be aware of applicable state requirements for reporting to the licensing authority those patients whose impairments may compromise their ability to operate a motor vehicle safely. (e) Prior to reporting, explain to the patient (and family, as appropriate) that the physician may have an obligation to report a medically at-risk driver: (i) when the physician identifies a medical condition clearly related to the ability to drive; (ii) when continuing to drive poses a clear risk to public safety or the patient's own well-being and the patient ignores the physician's advice to discontinue driving; or (iii) when required by law.(f) Inform the patient that the determination of inability to drive safely will be made by other authorities, not the physician. (g) Disclose only the minimum necessary information when reporting a medically at-risk driver, in keeping with ethics guidance on respect for patient privacy and confidentiality.

Sources:

1. Keeney, A., (1976). The visually impaired driver and physician responsibilities. (American Journal of Ophthalmology) 83: 799-801.
2. American Medical Association, (2003) Physicians guide to assessing and counseling older drivers. pp. 1-49. a. Essential Quote: "Although many states currently require far visual acuity for 20/40 for an unrestricted license, current research indicates that there is no scientific basis for this cut-off. In fact, studies undertaken in some states have demonstrated that there is no increased crash risk between 20/40 and 20/70 resulting in several new state requirements" page 45.
3. Rubin, G., Ng, E., et al., (2007) A prospective, population-based study of the role of visual impairment in motor vehicle crashes among older drivers: the SEE Study. (Investigative Ophthalmology & Visual Sciences) 48, (4) :1483-1491. a. Essential Quote: "Conclusions: Glare sensitivity, visual field loss and UFOV (useful field of vision) were significant predictors of crash involvement. Acuity, contrast sensitivity and stereo acuity were not associated with crashes. These results suggest that current vision screening for driver's licensure, based primarily on visual acuity, may miss important aspects of visual impairment." Owsley, C., Mc Gwin, G., (2010) Vision and driving. (Vision Research) 50:2348-2361. a. Essential Quote: "Based upon the research to date it is clear that if there is an association between visual acuity and driver safety, it is at best weak,...how does one rectify this conclusion in light of the significant findings from performance-based studies? One important consideration in this regard is that visual acuity related driving skill (e.g., sign recognition many not be crucial to the safe operation of a vehicle. Reading signage may be important for route planning or maintaining regulatory compliance with the "rule of the road" but it may not be critical for collision avoidance. " Owsley, C., Wood,. J., et al., (2015). A road map for

interpreting the literature on vision and driving. (Survey of Ophthalmology) 60:250-262. Tervo, T., (2018) Driver's health and fitness as a cause of a fatal motor vehicle accident in Finland. (The Eye, The Brain, and The Auto) 2018 (Link and /or abstract available from CAR author PCH). Keeney, A., (1976) The visually impaired driver and physician responsibilities. (American Journal of Ophthalmology) 82 (5):799-801. Fonda, G., (1989) Legal blindness can be compatible with safe driving. (Ophthalmology) 96 (10):1457-1459. Appel, S., Brilliant, R., et al., (1990) Driving with visual impairment: Facts and Issues. (Journal of Visual Rehabilitation) 4: 19-31. Peli, E., (2008) Driving with low vision: who, where, when and why. In Robert Massof, editor. (Albert and Jokobiec's Principles and Practice of Ophthalmology) 3rd Ed. Philadelphia, PA. Elsevier, 5369-5376. PLoS ONE

4. Johnson, C., Keltner, J., (1983) Incidence of visual field loss in 20,000 eyes and its relationship to driving performance. (Archive Ophthalmology) 10: 371-375. Wood, J., Troutbeck, R., (1992) Effect of restriction of the binocular visual field on driving performance. (Ophthal. Physiol. Opt.) 12: 291-298. Seculer, A., Bennett, P., et al., (2000) Effects of aging on the useful field of vision. (Experimental Aging research) 26: 103-120. Mc Gwin, G., Xie, A., et al., (2005) Visual field defects and the risk of motor vehicle collisions among patients with glaucoma. (Investigative Ophthalmology & Visual Science) 46 (12): 4437-4441. Wood, J., Mc Gwin, G., et al., (2009) On-road driving performance by persons with hemianopia and quadrantanopia. (Investigative Ophthalmology & Visual Science) 50(2):577-585.
5. Kasneci, E., Sipple, K., et al., (2014) Driving with binocular visual field loss? (Journal of Alzheimer's Disease and Head Tracking) PLoS ONE 9 (2):e8.7470) dol: 10.1371/journal.pone.0087470 Coyne, A., Feins, R., (1993) Driving patterns of dementia diagnostic clinic out patients. (New Jersey Medicine) 90: 615. Bedard, M., Molloy, D., (1998) Factors associated with motor vehicle crashes in cognitively impaired older adults. (Alzheimer Disease and Associated Disorders) 12: 135-139. Duchek, J., Hunt, L., et al., (1998) Alzheimer changes are common in aged drivers killed in single car crashes at intersections. (Forensic Science International) 96: 115-126.
6. Carr, D., (2000), The older adult driver. (American Family Physician)
7. Stutts, J., (2003). Driver Distraction and Traffic Crashes. (The Eye and The Auto) Link and/or abstract available from CAR author PCH. Coben, J., Zju, M., (2013). Keeping an eye on distracted driving. (Journal American Medical Association) 309:877-878. Lappin, J., (2020) Measuring the rate of human perception and the cost of spreading attention (The Eye, The Brain and The Auto) Lappin: https://vimeo.com/491423747.
8. MSMS Resolution #8-2019 AMA Resolution #427, June 2019
9. Stutts, J., (2003). Driver Distraction and Traffic Crashes. (The Eye and The Auto) Link and/or abstract available from CAR author PCH. Coben, J., Zju, M., (2013) Keeping an eye on distracted driving. (Journal American Medical Association) 309:877-878. Lappin, J., (2020) Measuring the rate of human perception and the cost of spreading attention (The Eye, The Brain and The Auto) Lappin: https://vimeo.com/491423747.
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11. Council Advisory Recommendation. CAR: 21-03. Shinar, D., (1977) Driver Visual Limitations, Diagnosis and Treatment. (NHTSA, US Department of Transportation, National Technical Information Service, Springfield, VA).

RESOLUTION 10-21

Title: Financial Impact and Fiscal Transparency of the American Medical Association Current Procedural Terminology Program

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Patrick Droste, MD, and Megan Edison, MD

Referred To:

House Action:

Whereas, the 2020 COVID-19 pandemic and restrictions brought unprecedented financial strain upon physicians, with the most recent Physician Foundation survey showing 12 percent of physicians either closing or planning to close their practice within the next year (75 percent of those physicians are in private practice), and nearly 75 percent of physicians reported lost income, and

Whereas, in the middle of this crisis, the new AMA Current Procedural Terminology® (CPT®) Evaluation and Management coding system went live on January 1, 2021, completely changing the Evaluation and Management (E&M) coding system and reimbursement for the first time in 24 years, and

Whereas, the timing of this change could not have come at a worse time for physicians still reeling from the pandemic and new insurance contracts not yet negotiated, and

Whereas, each patient encounter and experience is unique, and attempts to create a system to accurately reflect the care given within hundreds of specialties and thousands of patient visits is very difficult and likely to be inadequate, and

Whereas, failure to account for all patient interactions and care within a medical coding system will financially harm physicians in these overlooked areas of medicine, and

Whereas, the adverse consequences of the new CPT® system have not been studied, but early feedback among physicians shows this new CPT® system focuses on chronic care, thereby excluding nearly every pediatric diagnosis, and

Whereas, the new CPT® system rewards ordering prescriptions, lab tests, and studies, rather than watchful waiting and counseling, and

Whereas, the new CPT® system prevents private practice physicians from counting in-house labs and studies towards the complexity of care, but allows hospital employed physicians to do so, and

Whereas, the new CPT® system awards higher levels of reimbursement for curb siding a specialist, thereby encouraging and codifying a system of uncompensated care by specialists, and

Whereas, while the intent of this coding change may have been noble, the fallout and failures need to be studied and modified to create a fair system among private and employed physicians, reflective of the complexity of care within all specialties, and respectful of uncompensated care by our specialist colleagues, and

Whereas, the physicians in this country deserve to know the finances behind the AMA CPT® coding system that we are required to participate in; therefore be it

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) request that our AMA study and report the financial impact of the new 2021 CPT® Evaluation and Management coding system upon physicians, among all specialties, in private and employed practices; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to publicly disclose all revenue generated by the proprietary CPT® program in a transparent fashion, including but not limited to licensing fees, royalties, electronic health record fees, government and institutional licensing fees, handbooks, training programs, coding apps, and print-based coding resources in a yearly report.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions only requesting new or revised MSMS or AMA policy - $500

STATEMENT OF URGENCY: The 2021 American Medical Association (AMA) Current Procedural Terminology® (CPT®) Evaluation and Management went live on January 1, 2021. It is currently affecting physician reimbursement. Failure to address any potential harm in a timely manner will result in more practice closures and worsen patient access to physicians. This resolution asks the AMA to study and provide fiscal transparency on an issue that is very pertinent to practicing physicians right now.

Relevant MSMS Policy:
None

Relevant AMA Policy:

AMA CPT Editorial Panel and Process H-70.973
The AMA will continue (1) to work to improve the CPT process by encouraging specialty societies to participate fully in the CPT process; (2) to enhance communications with specialty societies concerning the CPT process and subsequent appeals process; and (3) to assist specialty societies, as requested, in the education of their members concerning CPT coding issues.

Preservation of Evaluation/Management CPT Codes H-70.985
It is the policy of the AMA to (1) oppose the bundling of procedure and laboratory services within the current CPT Evaluation/Management (E/M) services;
(2) oppose the compression of E/M codes and support efforts to better define and delineate such services and their codes;
(3) seek feedback from its members on insurance practices that advocate bundling of procedures and laboratory services with or the compression of codes in the CPT E/M codes, and express its views to such companies on behalf of its members;

(4) continue to work with the PPRC and all other appropriate organizations to insure that any modifications of CPT E/M codes are appropriate, clinically meaningful, and reflective of the considered views of organized medicine; and
(5) work to ensure that physicians have the continued opportunity to use CPT as a coding system that is maintained by the medical profession.

Use of CPT Editorial Panel Process H-70.919
Our AMA reinforces that the CPT Editorial Panel is the proper forum for addressing CPT code set maintenance issues and all interested stakeholders should avail themselves of the well-established and documented CPT Editorial Panel process for the development of new and revised CPT codes, descriptors, guidelines, parenthetic statements and modifiers.

CPT Coding System H-70.974
1. The AMA supports the use of CPT by all third party payers and urges them to implement yearly changes to CPT on a timely basis.
2. Our AMA will work to ensure recognition of and payment for all CPT codes approved by the Centers for Medicare & Medicaid Services (CMS) retroactive to the date of their CMS approval, when the service is covered by a patient's insurance.

Physicians' Current Procedural Terminology H-70.972
The AMA (1) continues to seek ways to increase its efforts to communicate with specialty societies and state medical associations concerning the actions and deliberations of the CPT Maintenance process; (2) urges the national medical specialty societies to ensure that their representatives to the CPT process are fully informed as to their association's policies and coding preferences; and (3) urges those specialty societies that have not nominated individuals to serve on the CPT Advisory Committee to do so.

Source:
http://physiciansfoundation.org/wp-content/uploads/2020/08/20-1278-Merritt-Hawkins-2020-Physicians-Foundation-Survey.6.pdf

RESOLUTION 15-21

Title: Electronic Prescribing Waiver for Michigan's Free Clinics

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Michelle M. Condon, MD, FACP

Referred To:

House Action:

Whereas, there are 57 free clinics for patients who obtain medical care from non-profit charitable medical clinics mostly because they do not have health insurance in Michigan, and

Whereas, approximately one-third of these clinics, have not had sufficient funds to switch to electronic medical records, and

Whereas, these clinics are largely run with all volunteer personnel and are financed by donations and the occasional grant, and

Whereas, many clinics are open less than 25 hours per week, and

Whereas, some volunteer retired physician personnel have resigned from these clinics rather than learn a (or another) medical records system, and

Whereas, patients generally shop multiple pharmacies to find the least expensive source for their medications thus requiring additional valuable staff time to discontinue electronic prescriptions sent to pharmacies in order to support patients' efforts to source their medication at a lower price, perhaps having found it at an alternative pharmacy; therefore be it

RESOLVED: That MSMS supports the Free Clinics of Michigan in asking the Michigan Department of Licensing and Regulatory Affairs (LARA) and the Michigan Board of Pharmacy to change the initial proposed language of Michigan Administrative Code Section R, 338.3162a (5)(a)(v), not yet posted for public comment, to allow a waiver for non-profit charitable medical clinics excusing them from being required to submit all prescriptions to pharmacies in electronic form.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: The business of the MSMS HOD addresses issues of physicians from all over Michigan, in a timely fashion, to improve the delivery of care, patient care issues and important policy and legislative issues affecting our members. Listening to the voice of physicians is paramount in organized medicine and is why many of our members participate at the county and state levels. Physician authors have taken the time during this busy and stressful time to articulate the issues. It is time to get back to the business of medicine for the sake of over-stressed

colleagues and their patients to address what is important to them, our members. The result can be improved transparency, updated physicians, or improved issues that affect patients in Michigan and/or across the country.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 16-21

Title: Medicaid Dialysis Policy for Undocumented Patients

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Authors: Michelle Condon, MD, FACP, and David Whalen, MD

Referred To:

House Action:

Whereas, in most states undocumented migrants with end stage kidney disease (ESKD) are ineligible for public assistance and rely on sessions of emergency dialysis when symptoms become intolerable, and

Whereas, in most states, undocumented migrants access to care is limited to safety-net providers, including hospital Emergency Departments (EDs) that are required to provide emergency care under federal Emergency Medical Treatment and Labor Act (EMTALA), and then have to wait until their symptoms qualify for ED admission for care to be reimbursed by emergency Medicaid program funding, and

Whereas, the five year mortality rate on emergency dialysis is 14 times higher than standard care, and costs up to $400,000 per patient annually compared to $100,000 in the outpatient setting, and

Whereas, undocumented ESKD patients are often younger with fewer comorbidities than other ESKD patients, making them often ideal candidates for transplantation, but usually they cannot qualify due to lack of insurance to cover the high cost of immunosuppressive therapy, and

Whereas, caring for these patients exerts a toll on physicians resulting in signs of burnout stemming from the feeling that they were being forced to provide substandard care, and

Whereas, undocumented patients can purchase commercial plans at full price due to a provision in the Affordable Care Act (ACA) forbidding companies from denying coverage based on preexisting conditions, and

Whereas, some states have allowed patients to automatically qualify for outpatient dialysis care after presenting to a hospital; therefore be it

RESOLVED: That MSMS ask the State of Michigan to develop a dialysis policy for undocumented patients with end stage kidney disease as an emergency condition covered under Medicaid; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask the AMA to work with the Center for Medicare and Medicaid Services and other state Medicaid programs to develop a dialysis policy for undocumented patients with end stage kidney disease as an emergency condition covered under Medicaid.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: This is a timely issue that should be addressed promptly for physicians and underserved, low-income patients. It is an access-to-care issue for many patients.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

RESOLUTION 17-21

Title: Surrogacy Options for Michigan Parents

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Adam J. Rush, MD

Referred To:

House Action:

Whereas, the AMA supports surrogate parenting "also termed Third Party Reproduction" as a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child, and

Whereas, such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child, and

Whereas, gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires, and

Whereas, in the United States, individual states have the power to determine the legality of surrogacy agreements and surrogate compensation, and

Whereas, the state of Michigan is one of only three states that are outliers on surrogacy law, and

Whereas, in the state of Michigan statute prohibits compensated surrogacy contracts, and a birth certificate naming both intended parents cannot be obtained, and

Whereas, the state of New York in February 2021, made compensated surrogacy legal, and

Whereas, in 1998, MSMS endorsed the need to define and protect the legal status and rights of a child born as a result of surrogate parenting, and

Whereas, in 2018, Senator Rebekah Warren (D-Warren) introduced Senate Bill 1082 which to repeal Michigan's current law and replace it with the Gestational Surrogate Parentage Act, but it failed to advance; therefore be it

RESOLVED: That MSMS work with the Michigan legislature to amend the current law to assist parents and newborns in Michigan, clarify parenting rights, and support compensated surrogacy options.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: This is a timely issue that should be addressed promptly for physicians and patients. In light of recent legislative discussions at the state and/or local level, physicians need to be involved in updating this legislation.

Relevant MSMS Policy:

Surrogate Parenting
MSMS endorses the need to define and protect the legal status and rights of a child born as a result of surrogate parenting. MSMS endorsement does not extend to the process of surrogate parenting. (Prior to 1990)

Relevant AMA Policy:

4.2.4 Third-Party Reproduction
Third-party reproduction is a form of assisted reproduction in which a woman agrees to bear a child on behalf of and relinquish the child to an individual or couple who intend to rear the child. Such arrangements can promote fundamental human values by enabling individuals or couples who are otherwise unable to do so to fulfill deeply held desires to raise a child. Gestational carriers in their turn can take satisfaction in expressing altruism by helping others fulfill such desires.

Third-party reproduction may involve therapeutic donor insemination or use of assisted reproductive technologies, such as in vitro fertilization and embryo transfer. The biological and social relationships among participants in these arrangements can form a complex matrix of roles among gestational carrier, gamete donor(s), and rearing parent(s).

Third-party reproduction can alter social understandings of parenthood and family structure. They can also raise concerns about the voluntariness of the gestational carrier's participation and about possible psychosocial harms to those involved, such as distress on the part of the gestational carrier at relinquishing the child or on the part of the child at learning of the circumstances of his or her birth. Third-party reproduction can also carry potential to depersonalize carriers, exploit economically disadvantaged women, and commodify human gametes and children. These concerns may be especially challenging when carriers or gamete donors are compensated financially for their services. Finally, third- party reproduction can raise concerns about dual loyalties or conflict of interest if a physician establishes patient-physician relationships with multiple parties to the arrangement.

Individual physicians who care for patients in the context of third-party reproduction should:

(a) Establish a patient-physician relationship with only one party (gestational carriers, gamete donor[s] or intended rearing parent[s]) to avoid situations of dual loyalty or conflict of interest.

(b) Ensure that the patient undergoes appropriate medical screening and psychological assessment.

(c) Encourage the parties to agree in advance on the terms of the agreement, including identifying possible contingencies and deciding how they will be handled.

(d) Inform the patient about the risks of third-party reproduction for that individual (those including individuals), possible psychological harms to the individual(s), the resulting child, and other relationships.

(e) Satisfy themselves that the patient's decision to participate in third-party reproduction is free of coercion before agreeing to provide assisted reproductive services.

Collectively, the profession should advocate for public policy that will help ensure that the practice of third-party reproduction does not exploit disadvantaged women or commodify human gametes or children.

Sources:

1. Third-Party Reproduction, The AMA Code of Ethics Opinion 4.2.4. www.ama-assn.org/delivering-care/ethics/third-party-reproduction
2. The United States Surrogacy Law Map. www.creativefamilyconnections.com/us-surrogacy-law-map
3. Surrogate Parenting Act. http://legislature.mi.gov/doc.aspx?mcl-act-199-of-1988
4. The Child-Parent Security Act. http://health.ny.gov/vital_records/child_parent_security_act
5. Senate Bill 1082 (2018). http://legislature.mi.gov/doc.aspx?2018-SB-1082

RESOLUTION 18-21

Title: Medical and Dental Care for Prisoners

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Patrick J. Droste, MS, MD

Referred To:

House Action:

Whereas, prisoners in correctional facilities have the right to receive timely medical and dental care, and

Whereas, prisoners in correctional facilities frequently have medical and dental problems that are not addressed by prison authorities, and

Whereas, prisoners do not have internal prison advocates to support their quest for medical and/or dental care, and

Whereas, prisoners get charged for each request of medical or dental service and may not have the funds to pay for such visits, and

Whereas, prisoners have no recourse to request second opinion or specialty evaluation for unresolved medical or dental concerns, and

Whereas, family members of prisoners, serving as an advocate, find it difficult to facilitate appropriate medical care or obtain information regarding a prisoner's condition(s), and

Whereas, prisoners are frequently transferred to multiple prison facilities throughout their sentence, which leads to lack of continuity of care; therefore be it

RESOLVED: That MSMS work with the Michigan Department of Corrections to establish viable and effective protocols to allow prisoners to present their medical concerns and receive timely responses to their request for medical and dental care; and be it further

RESOLVED: That MSMS support the development of a Review Board, composed of correctional officials, medical professionals such as physicians, nurses, or physician assistants and prisoners, to review inmates concerns regarding medical and dental diagnosis and treatment.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: We feel that the MSMS-HOD should hear and act on this resolution in 2021 and give it highest consideration, because prisoners are being denied timely and affordable

medical and dental care during their period of confinement. This neglect of care makes it more difficult for them to rehabilitate both inside the correction facilities and after their discharge.

Relevant MSMS Policy:
None

Relevant AMA Policy:
None

Source:
Kimberly Norris, MD, of Barry County

RESOLUTION 19-21

Title: De-professionalization of the Medical Profession

Introduced by: David Whalen, MD, for the Kent County Delegation

Original Author: Patrick J. Droste, MS, MD

Referred To:

House Action:

Whereas, physicians attend medical school, complete an internship, and residency training before being credentialed as a fully licensed physician, and

Whereas, physicians complete a rigorous series of board examinations during medical school, internship, and residency to certify their ability to diagnosis and treat patients, and

Whereas, physicians are regarded as the legal entity that is ultimately responsible for patient care, and

Whereas, health care workers are encouraged to address physicians by their first name rather than doctor, in order to lessen the "authority gradient" related to patient safety, and

Whereas, physicians-in-training are being encouraged to perform as active team members in patient care and are not being recognized as medical students or resident physicians, which potentially leads to confusion about leadership and accountability within the team, and

Whereas, medical schools are utilizing Advanced Practice Professionals as educators for future physicians, implying that the training of Advanced Practice Professionals is equivalent to the training of physicians, and

Whereas, physicians are still held professionally and legally accountable for outcomes, including adverse outcomes, of team-based care due to the higher level of training involved and the role as the team leader; therefore be it

RESOLVED: That MSMS supports only the use of titles and descriptors that align with a physician or non-physician provider's state issued licenses or credentials; and be it further

RESOLVED: That MSMS actively oppose efforts to diminish the qualifications and training of physicians by hospital administrators, insurance companies, and governmental regulatory agencies who require physicians be referenced as medical providers, team members, health care providers, or any other reference in lieu of the legal title of physician or doctor; and be it further

RESOLVED: That MSMS seek legislation which provides that professionals in a clinical health care setting clearly and accurately identify to patients their qualifications and degree(s) attained as follows:

1. Wear an identification badge which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc.), to differentiate between those who have achieved a Doctorate, and those with other types of credentials. The font size of their credentials shall be greater than the front size used for their name for the purpose of role definition and patient safety.
2. Anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who has not received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine, shall specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

WAYS AND MEANS COMMITTEE FISCAL NOTE: Resolutions requesting governmental advocacy - $25,000+

STATEMENT OF URGENCY: We encourage the highest consideration for this resolution to be evaluated and acted upon by the Michigan State Medical Society-House of Delegates-2021. The medical profession has been victim of a well-organized downgrading of professional merit and expertise by providers who want to pay less for physician provided medical services by comparing them to advanced practice providers (APP). Hospital administrators want to decrease the "authority gradient" by removing titles in correspondence and video meetings and calling physicians by their first name. Pharmacists, physical therapists and nurses all offer doctorate degrees and want their graduates to be recognized by the public and hospitals as "Doctors." This creates a very confusing environment for patient satisfaction and safety and a very disturbing environment for physicians. This movement has been growing for over thirty years, with little tangible resistance by the medical profession and we feel that something legislative needs to be started this year by the MSMS to start reversing this overt devaluation of our profession.

Relevant MSMS Policy:

Calling Physicians by their First Name
MSMS discourages policies that require physicians to be called by their first names in professional settings such as their workplace. (Res42-16)

Physician Not Labeled as Provider
MSMS opposes the current custom by government and insurance companies of labeling physicians as providers and encourages proper identification of physicians and/or surgeons.
MSMS supports physicians who request they be identified as "physicians" apart from other "providers" on any contracts or documents they are asked to sign. (Res38-90A) – Amended 1993 – Edited 1998 -Reaffirmed (Sunset Report 2020)

Relevant AMA Policy:

"Doctor" as a Title H-405.992
The AMA encourages state medical societies to oppose any state legislation or regulation that might alter or limit the title "Doctor," which persons holding the academic degrees of Doctor of Medicine or Doctor of Osteopathy are entitled to employ.

Clarification of the Title "Doctor" in the Hospital Environment D-405.991

1. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement standards for an identification system for all hospital facility staff who have direct contact with patients which would require that an identification badge be worn which indicates the individual's name and credentials as appropriate (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), to differentiate between those who have achieved a Doctorate, and those with other types of credentials.

2. Our AMA Commissioners will, for the purpose of patient safety, request that The Joint Commission develop and implement new standards that require anyone in a hospital environment who has direct contact with a patient who presents himself or herself to the patient as a "doctor," and who is not a "physician" according to the AMA definition (H-405.969, ?that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine?) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.

3. Our AMA will request the American Osteopathic Association (AOA) to (1) expand their standards to include proper identification of all medical staff and hospital personnel with their applicable credential (i.e., MD, DO, RN, LPN, DC, DPM, DDS, etc), and (2) Require anyone in a hospital environment who has direct contact with a patient presenting himself or herself to the patient as a "doctor", who is not a "Physician" according to the AMA definition (AMA Policy H-405.969 .. that a physician is an individual who has received a "Doctor of Medicine" or a "Doctor of Osteopathic Medicine" degree or an equivalent degree following successful completion of a prescribed course of study from a school of medicine or osteopathic medicine) must specifically and simultaneously declare themselves a "non-physician" and define the nature of their doctorate degree.