The Indiana State Medical Association

Public Policy Manual

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ADVERTISING

(6/10/84, BOT) Reaffirmed its position that the ISMA continue to use the American Medical Association's guidelines pertaining to advertising as contained in its "Reference Guide to Policy & Official Statements" and its "Current Opinions of the Council on Ethical and Judicial Affairs."

AIDS (ACQUIRED IMMUNE DEFICIENCY SYNDROME)

(READOPTED 11-52, HOD; RESOLUTION 01-22) RESOLVED, that the ISMA advocate to the Indiana General Assembly and the Indiana State Department of Health mandatory HIV testing for all pregnant women and the newborn infant if the mother is HIV positive. *(Passed 2003, HB 1630).*

(READOPTED 11-16, HOD; RESOLUTION 01-23) RESOLVED, that the ISMA support legislative change to exempt health care workers from having to obtain consent for HIV testing in situations where a health care worker is inadvertently exposed to blood or other biological contamination from patients in the course of medical care. All other statutes of the law must remain in effect.

(READOPTED 09-45, HOD; READOPTED 99, HOD; RESOLUTION 89-42) RESOLVED, that: (1) the ISMA support and endorse a program that requires more broad-based testing for HIV; (2) upon reporting of a positive result (confirmatory), the Indiana State Department of Health would be required to begin case-finding and case-contacting activities with those individuals who have been reported as testing positive, as with many other STDs; and (3) hospital admittees should be appropriately tested for HIV; and be it further,
RESOLVED, that the ISMA's position on Human Immunodeficiency Virus (HIV) is that it should be treated as an infectious disease so that we may maintain control until a cure is found.

(READOPTED 08-10, HOD; RESOLUTION 98-10) RESOLVED, that the ISMA endorse and support HIV testing as a part of routine testing during the first trimester of pregnancy; and be it further,
RESOLVED, that the ISMA support the concept that all pregnant mothers be given material about and counseling for HIV disease. *(2nd Resolved passed 2003, HB 1630).*

(8/25/91, BOT) Approved the CDC guidelines and AMA policy on HIV/HBV infected health care workers.

(8/13/89, BOT) 1989 HOD filed the following Supplementary Board Report:

Delivery of care - While the ISMA recognizes that physicians have an ethical obligation to treat all patients, it believes physicians should recognize any limitations of their training and expertise and refer an AIDS patient to a specialist if the patient would receive better treatment.

Discrimination - The ISMA recognizes that the cause of AIDS is a virus, not aberrant social behavior, and condemns discrimination of any sort against AIDS/HIV positive patients. The ISMA applauds the position adopted by the Indiana Civil Liberties Union making AIDS discrimination an unlawful activity in this state.

Education - Supported mandatory sex education and drug education, beginning in kindergarten and continuing through elementary and secondary schools. While the ISMA encourages physician education, it finds no evidence to support imposing mandatory AIDS education on physicians. The ISMA supports the concept of the Indiana State Board of Health funding regional AIDS treatment and educational centers.

Health care workers - The ISMA believes that the decision for HIV-infected health care workers to continue patient contact is a decision that must be determined on an individual basis, based on the opinions of the worker's personal physicians and the medical directors of the employing institution.

Testing - While the ISMA recognizes that the testing issue raises a variety of ethical, legal and financial concerns, it believes the following principles should be observed in the design of testing procedures:

- Testing should be an individual physician/patient decision, not a regulatory issue.
- There should not be legal impediments to testing when a treating physician feels it is appropriate.
- For epidemiological purposes, the ISMA supports an increase in the prevalence of anonymous testing.
- The ISMA supports the development of anonymous and confidential testing mechanisms.

AFFORDABLE CARE ACT (ACA)/HEALTH CARE REFORM

(RESOLUTION 16-33) RESOLVED, that the ISMA ask the AMA House of Delegates to no longer support the ACA in its current form and to work for replacement or substantial revision of the act to include these changes:

- Allowing health insurance to be sold across state lines
- Allowing all businesses to self-insure and to purchase insurance through business health plans or association health plans
- Improving the individual mandate with a refundable tax credit that would be used to purchase health insurance
- Improving health-related savings accounts so as to help ACA insureds afford their higher deductibles and co-pays
- Reversing cuts to traditional Medicare and Medicare Advantage programs
- Encouraging states to develop alternatives to Medicaid by using federal funds granted under provisions of the ACA
- Eliminating all exemptions, loopholes, discounts, subsidies and other schemes to be fair to those who cannot access such breaks in their insurance costs; and be it further

RESOLVED, that the ISMA encourage the AMA to maintain the following provisions to the ACA if it is replaced:

- Full coverage of preventive services
- Family insurance coverage of children living in a household until age 26
- Elimination of lifetime benefit caps
- Guaranteed insurability

(RESOLUTION 13-47) RESOLVED, that the ISMA support the following health care reform concepts:

- A competitive health care free market;
- Increasing access to portable, affordable health insurance;
- Expanding access to health savings accounts;
- Improving access to insurance for vulnerable Americans;
- Medical liability reform which does not compromise Indiana's current, effective reforms;
- Repeal of the Medicare Sustainable Growth Rate Formula;
- Repeal of the Medicare Independent Payment Advisory Board; and
- Emphasis on patient involvement and personal accountability.

(RESOLUTION 13-29) RESOLVED, that the ISMA delegation as the AMA House of Delegates to consider the following recommendations:

1. Replace the individual mandate with a refundable tax credit that could only be used to purchase health insurance.
2. Repeal the employer mandate. Businesses, as well as individuals, should be allowed to purchase health insurance with pretax dollars.
3. Allow health insurance to be sold across state lines. Health insurance should be portable and should follow the individual from job to job and state to state.
4. Allow small businesses to self-insure or purchase insurance through small business health plans or association health plans. Currently, this option is available only to large businesses.
5. Improve health-related savings accounts and consumer-driven health care plans by allowing higher deductibles and high savings account contributions.
6. Allow and encourage states to develop alternatives to Medicaid by using federal funds granted by the Health and Human Services Secretary under provisions of the ACA.

7. Restore funds cut from traditional Medicare.
8. Avoid reducing Medicare Advantage funding. This insurance is highly popular with seniors.
9. Eliminate the unaccountable and unpopular Independent Payment Advisory Board.
10. Eliminate involvement in the ACA by the Internal Revenue Service.
11. Maintain the guaranteed insurability, full coverage of preventative services and elimination of lifetime benefit caps under the ACA.
12. Continue the family insurance coverage of children living in a household until age 26.
13. Eliminate the taxes on medical devices and pharmaceuticals and health insurance companies since this added expense would only be passed on to our patients.
14. Repeal and replace the sustainable growth rate formula.
15. Enact meaningful medical liability reform.
16. Expand the funding of medical schools and residency programs in order to increase the number of physician providers.
17. Cancel all current ACA waivers, exemptions, subsidies and discounts except for those based on patient income under provisions of the ACA. Prohibit any of these in the future unless they are based on income of the patient.
18. Prohibit any future insurance plans that are alternatives to the ACA for all federal employees, members of Congress, federal judges and the president, as well as their dependents.
19. Due to the complexity of improving the ACA, its implementation should be delayed at least one year.
20. Finally, Congress should be asked to appoint a committee with a majority membership of health care providers and AMA leadership with a mandate to revise Medicare and to produce a plan that would allow its long-term viability and adequate health benefits for seniors and the disabled. The same committee would also work to identify the changes that would effectively improve the AVA and allow for its long-term vitality.

(RESOLUTION 10-18) RESOLVED, that ISMA policy support and that the ISMA support legislation to obtain and utilize as much of the $250,000,000 appropriated for state grants from the Patient Protection and Affordable Health Care Act for the benefit of full health insurance disclosure and public education in Indiana.

..ALCOHOL

(RESOLUTION 16-04) RESOLVED, that the ISMA actively support a coordinated drug and alcohol program funded by the state for treatment of inmates in local jails to help stop the current recycling of inmates who, upon release, return to their old habits of drug and alcohol use.

(READOPTED AND AMENDED 10-48; RESOLUTION 00-27) RESOLVED, that blood alcohol and chemical testing be mandated for all drivers involved in all motor vehicle accidents with fatalities or serious bodily injury.

(READOPTED 10-32, HOD; READOPTED 00-25, HOD; RESOLUTION 98-29) RESOLVED, that the ISMA continue to support efforts to reduce underage drinking by increasing the minimum age of sellers of alcoholic beverages to 21 and requiring responsible beverage service training for all servers of alcoholic beverages.

(RESOLUTION 08–24) RESOLVED, that the ISMA support legislation requiring mandatory ID checks for alcohol purchases for anyone who appears under age 30 (similar to ID checks for tobacco); and be it further, RESOLVED, that the ISMA support legislation that would provide education for prevention of underage drinking, and treatment of alcohol-related problems.

(READOPTED 17-19, RESOLUTION 07-19) RESOLVED, that the ISMA support increasing the tax on alcohol with revenue from the tax allocated to improving the health of Hoosiers.

ALLIANCE, ISMA

(RESOLUTION 16-30) RESOLVED, that the ISMA continue to financially support the Alliance at $4 per member.

(READOPTED 10-46, HOD; RESOLUTION 00-05A) RESOLVED, that the ISMA retain the current funding to the ISMA Alliance of $4 per ISMA member as adopted in 2000.

ALTERNATIVE MEDICINE

(RESOLUTION 10-27) RESOLVED, that the ISMA initiate regulatory or statutory change requiring insurers to provide physicians a list of alternative FDA-approved medications that do not require prior authorization with the denial notification.

(1/20/99, BOT) Accepted the ISMA Alternative Medicine Task Force's recommendations for non-licensure of the following activities. Specific recommendations for these activities are noted below.

- Therapeutic Touch - The use of hands to restore areas of blockage in a patient's energy field.
  - *Recommendation*: Specific guidelines for therapeutic touch are neither recommended nor necessary.
- Body-Mind Intervention - The practice of influencing the body's own healing response through psychological interventions.
  - *Recommendation*: Body-mind intervention is broad in spectrum and used in everyday practices of many traditional practitioners and therapists. Appropriate training and certification in the underlying disciplines are recommended. Mind-body interventions are, in general, supported by the scientific literature. However, some mind-body interventions are less studied and not as well documented.
- Chelation - Incorporation of a metal ion into a heterocyclic ring structure -- In alternative medicine practices, chelation refers to the use of chelating agents to reverse atherosclerotic vascular disease and thus decrease angina pectoris and claudication.
  - *Recommendation*: The use of chelation solution for the treatment of atherosclerosis is an off-label use and not approved by the U.S. Food and Drug Administration (FDA). There are no valid scientific studies showing beneficial effects using chelating agents to reverse atherosclerosis. The Task Force recommends chelating agents only be used for FDA approved conditions (e.g. heavy metal poisoning).
- Reflexology – The physical act of applying pressure to the feet and hands with techniques that do not utilize oil, cream or lotion. It is based on the principle that there are no more than seven thousand nerve endings in the feet relative to every organ, gland, tissue or muscle in the body.
  - *Recommendation*: Reflexology seems to be considered most often by people seeking pain relief, but there is no hard data substantiating the claims of the practitioners of reflexology. However, there does not appear to be any substantial harm that could result from treatment.
- Homeopathy – A natural pharmaceutical science utilizing plants, minerals or animals in very small doses to stimulate the sick person's natural defenses. The fundamental belief is that by giving a small amount of the offending substance, the patient's body seeks to reestablish balance. Thus, the homeopathic substances are felt to work with the patient's natural defense mechanisms.
  - *Recommendation*: Homeopathy has limited data supporting its efficacy and safety, though little risk has been identified. Homeopathic principles and treatments may complement allopathic treatment in certain conditions.
- Massage Therapy – The act of treating the body by rubbing the body to stimulate the circulation, to induce suppleness or to release endorphins. Massage therapy is currently a recognized alternative therapy by the Office of Alternative Therapies under the National Institutes of Health. Practitioners are eligible for certification through the American Massage Therapy Association.
  - *Recommendation*: Consumers should verify certification when using this alternative therapy.

(8/25/85, BOT) Support the position of the AMA that there is no scientific documentation that the use of chelation therapy is effective in the treatment of cardiovascular disease, arteriosclerosis, rheumatoid arthritis or

cancer; and further, if chelation therapy is to be considered a useful medical treatment for anything other than heavy metal poisoning, hyper-calcemia, or digitalis toxicity, it is the responsibility of its proponents to: (1) conduct properly controlled scientific studies; (2) adhere to U.S. Food and Drug Administration (FDA) guidelines for the investigation of drugs; and (3) disseminate results of scientific studies in the usual, accepted channels.

AMA/ISMA GOVERNANCE

(RESOLUTION 16-50) RESOLVED, that the ISMA encourage its candidates seeking election to reduce the cost of candidacy and the environmental cost of standard mailings by utilizing email for notification of candidacy unless otherwise requested by delegates.

(RESOLUTION 16-44) RESOLVED, that the ISMA Board of Trustees form a compensation subcommittee to annually review and determine elected leadership compensation; and be it further
RESOLVED, that an annual leadership compensation report be included in the annual report to the ISMA House of Delegates; and be it further
RESOLVED, that the ISMA Board of Trustees develop a number of strategies to facilitate the service of an employed-physician president; and be it further
RESOLVED, that the ISMA Board of Trustees develop informational material for employers of physicians interested in becoming ISMA president, with the goal of educating the employer on presidential service and demonstrating the value of the presidency to health care as a whole.

(RESOLUTION 16-35) RESOLVED, that the Indiana Delegation to the AMA:

- Post AMA election results to the ISMA website as soon as possible after election.
- That those results be available through a link, possibly entitled "ELECTION RESULTS (AMA).
- Announce appointments to commissions, committees and other positions by a similar link on the ISMA website, possibly entitled "RECENT APPOINTMENTS."

ASTHMA

(RESOLUTION 14-34) RESOLVED, that the ISMA adopt and promote a statewide asthma management plan that:

1. Requires physician supervision and/or a designated asthma care provider
2. Assures specific patient identifiers
3. Identifies school personnel responsible for interpreting the plan and administering medications
4. Allows school personnel to communicate directly with physician offices about the patients
5. Encourages physicians and school health personnel to adopt and use the Asthma Management Plan and Authorization for Medication form as included in this resolution.

(RESOLUTION 13-05) RESOLVED, that the ISMA support efforts to develop a statewide written asthma action plan.

BLOOD DONATIONS

(4/10/88, BOT) Approved the following Blood Bank Task Force recommendations:

- Since directed donors are no safer than volunteer donors, directed donor units should not be expected to be processed for emergency situations. Emergency care should not be delayed because of lack of directed donor units.
- Under usual circumstances, three days should be expected from the time the donor unit is drawn until the time that the donor unit arrives at the hospital.

- In order to maintain the integrity of the centralized blood system, the primary responsibility for autologous and directed donations should remain with the blood centers and not with individual hospitals. The blood centers in cooperation with the hospitals should continue to provide ready access and donor convenience for these services.

BODY MODIFICATIONS

(RESOLUTION 09-24) RESOLVED, that the ISMA seek legislation to include body modification to be clearly defined as the practice of medicine and that the legislation includes enforcement mechanisms at the county level.

CANCER PREVENTION

(RESOLUTION 17-15) RESOLVED, that ISMA support legislative efforts allowing students at schools, day cares and youth camps to bring, possess and be given adequate time to apply and to self-apply non-aerosol sunscreen when exposed to UV light without requiring physician authorization and without requiring storage and application in the nurse's office; and be it further
RESOLVED, that ISMA support legislative efforts allowing students at schools, day cares and youth camps to bring and wear sun-protective clothing when exposed to UV light, including hats and sunglasses that are not otherwise banned from school policy; and be it further
RESOLVED, that ISMA support legislative efforts that incorporate age-appropriate instruction on UV-protective behavior and skin cancer prevention in schools.

(RESOLUTION 12-44) RESOLVED, that the ISMA adopt policy supporting access to prostate cancer screening in adequately healthy and appropriately counseled men, and reject the United States Preventative Services Task Force recommendations against PSA screening.

(6/7/87, BOT) Approved the ISMA's participation in the Indiana State Board of Health's Breast Screening Awareness Project.

(READOPTED RESOLUTION 17-14, RESOLUTION 07-37) RESOLVED, that the ISMA adopt policy and seek legislation including, but not limited to:

- Prohibiting minors from using tanning devices;
- Posting the surgeon general's warning on all tanning devices;
- Prohibiting a person or facility from advertising the use of any ultraviolet A or ultraviolet B tanning device using such words as "safe", "safe tanning", "no harmful rays", "no adverse effect", or similar wording or concepts.

CERTIFICATE OF NEED

(READOPTED 15-13, HOD; RESOLUTION 05-49) RESOLVED, that the ISMA reaffirm its policy opposing state and local Certificate of Need programs and moratoria.

(1/13/80, BOT) Supported the ISMA continuing to vigorously oppose any certificate of need legislation and seeking the exclusion of physician offices should certificate of need legislation become inevitable.

CHARITY CARE, GUIDELINES FOR DETERMINATION OF

(9/25/09, BOT) Approved the following guidelines for Determination of Charity Care:

- Practices must determine the level of charity care provided to a patient by using consistently applied written guidelines. The physician practice is responsible for tailoring the guidelines based on location, specialty, or patient demographics that are most appropriate for the practice.
- The guidelines should consist of a charity care application, criteria for determining the level of charity care based on family size, ability to pay and insurance coverage. Practices should base charity care on the current year Federal Poverty Guidelines as determined by U.S. Department of Health and Human Services (http://aspe.hhs.gov/poverty/) (HHS). Lastly, charity care guidelines should only extend to those families with income less than four times the Federal Poverty Guidelines or to uninsured patients. In the case of an uninsured patient, practices may determine a fixed write-off percentage that is separate from the normal charity care policy. Only medically necessary services, as determined by the physician, are eligible for charity care.

CHILDHOOD OBESITY

(RESOLUTION 12-10) RESOLVED, that the ISMA seek and support legislation requiring the collection and submission of uniform body mass index (BMI) information for all students at predefined intervals as recommended by the Indiana State Department of Health; and be it further,
RESOLVED, that the ISMA seek and support legislation that allows the ISMA and the Indiana State Department of Health to regularly review and analyze height, weight and body mass index (BMI) information to evaluate the effectiveness of obesity prevention and intervention programs.

CLINICS

(READOPTED 09-43, HOD; READOPTED 99, HOD; RESOLUTION 89-28A) RESOLVED, that the ISMA, in cooperation with interested governmental offices and organizations such as the Indiana State Department of Education, the Indiana State Department of Health, the Indiana State Teachers Association, the Indiana School Boards Association and others, establish a mechanism to assure sound and reasonably available medical advice to elementary and secondary schools for development and interpretation of health policies and curricula.

(7/7/87, BOT) Endorsed opposition to school-based health clinics.

(3/5/78, BOT; 3/28/79, EC) Agreed with the Indiana Medical Licensing Board's interpretation of the Medical Practice Act which opposes independent practice of medicine by non-physicians, including the use of protocols for nurse practitioners and physicians' assistants as a substitute for close physician supervision. Additionally, ISMA opposes the concept of peripheral clinics, which utilize minimal supervision.

COLLECTIVE BARGAINING

(RESOLUTION 14-27) RESOLVED, that the ISMA support the principles of collective bargaining rights and employee associations for physicians in Indiana.

(READOPTED 09-57, HOD; RESOLUTION 99-29A) RESOLVED, that the ISMA study the voluntary, patient-oriented provisions of collective bargaining based on the AMA model legislation for collective bargaining.

(READOPTED 09-55, HOD; RESOLUTION 99-23) RESOLVED, that the ISMA work to educate members concerning a physician negotiating organization and solicit members' input concerning such an organization.

CORONERS

(RESOLUTION16-39) RESOLVED, the ISMA supports the following:

1) Requiring higher education in the form of an academic degree such as: MD, DO, DDS, DMD, DVM, RN, BSN, NP, DNP, or a masters or doctorate in a life science
2) Expanding the current basic coroner training course to at least 40 hours of classroom and/or web-based training before beginning services as a new coroner
3) Expanding the current ongoing training in the form of web-based and/or classroom-based continuing education to enhance knowledge and competency
4) Requiring consultation with a forensic pathologist in certain cases such as death of a child, unexplained death of an adult less than age 50, apparent overdose death, apparent suicides and death as a consequence of a crime
5) Requiring additional qualifications to be a coroner for Indiana counties with a population greater than 100,000
6) Establishing a policy that the ideal coroner for an Indiana county, especially a county with a large population, would be a forensic pathologist

CRIMINAL BACKGROUND CHECKS

(RESOLUTION 09-03) RESOLVED, that the ISMA encourage legislation in Indiana requiring a nationwide criminal background check on all applicants before hiring into a position in which they may be caring for vulnerable patients; and be it further,
RESOLVED, that the ISMA encourage the AMA to support federal legislation requiring a nationwide background check on applicants before hiring into a position in which they may be caring for vulnerable patients; and be it further,
RESOLVED, that ISMA encourage the AMA to support legislation to establish a nationwide criminal database.

DAYLIGHT SAVINGS TIME

(RESOLUTION 16-31) RESOLVED, that the ISMA initiate policy to end the observance of Daylight Savings Time in Indiana.

DEATH, DEFINITION OF

(RESOLUTION 17-04) RESOLVED, that ISMA adopt updated brain death guidelines for adults and children, as provided by the Ad Hoc Committee to establish Brain Death Guidelines for the state of Indiana for 2017.

Revision of ISMA Adult Brain Death Guidelines of 2017

ADULT GUIDELINES FOR DETERMINATIN OF BRAIN DEATH

ADULT DIAGNOSTIC CRITERIA- PATIENTS ABOVE 18 YEARS OF AGE I. **Diagnostic criteria for clinical diagnosis of brain death.** A. Prerequisites. Brain death is the absence of clinical brain function when the proximate cause is known and demonstrably irreversible. 1. Clinical or neuroimaging evidence of an acute CNS catastrophe that is compatible with the clinical diagnosis of brain death. 2. Exclusion of complicating medical conditions that may confound clinical assessment (no severe electrolyte, acid-base, or endocrine disturbance) 3. No drug intoxication or poisoning. 4. Core temperature $\geq$ 32° C (90° F).	3. Apnea-testing performed as follows: a) Prerequisites I. Core temperature $\geq$ 36° C or 97° F II. Systolic blood pressure $\geq$ 90 mm HG III. Euvolemia. Option: positive fluid balance in the previous 6 hours IV. Normal pCO_2 , *Option*: arterial pCO_2 $\geq$ 40 mm Hg V. Normal pO_2. *Option*: preoxygenation to obtain arterial pO_2 $\geq$ 200 mm Hg b) Connect a pulse oximeter and disconnect the ventilator. c) .

5. In any patient who has a recorded core body temperature of 34° C or lower, prior to or during hospitalization, a cerebral blood flow study must be performed which shows no cerebral blood flow before brain death can be declared by physical examination. A core body temperature of 36° C or higher should be maintained for at least 24 hours prior to initiating the brain death examination.

B. The three cardinal findings in brain death are coma or unresponsiveness, absence of brainstem reflexes and apnea.

1. Coma or unresponsiveness-no cerebral motor response to pain in all extremities (nail-bed pressure and supraorbital pressure).
2. Absence of brainstem reflexes
   a) Pupils
      i. No response to bright light
      ii. Size: midposition (4mm) to dilated (9mm).
   b) Ocular movement
      i. No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent)
      ii. No deviation of the eyes to irrigation in each ear with 50 ml of cold water (allow 1 minute after injection and at least 5 minutes between testing on each side)
   c) Facial sensation and facial motor response
      i. No corneal reflex to touch with a throat swab
      ii. No jaw reflex
      iii. No grimacing to deep pressure on nail bed, supraorbital ridge, or temporomandibular joint
   d) Pharyngeal and tracheal reflexes
      i. No response after stimulation of the posterior pharynx with tongue blade
      ii. No cough response to bronchial suctioning

c) If oxygen saturation falls to 85 % or less, abort the apnea test and reconnect the respirator; otherwise, continue with apnea test.

d) Look closely for respiratory movements (abdominal or chest excursions that produce adequate tidal volumes).

e) Measure arterial pO_2, pCO_2 and pH after approximately 8 minutes and reconnect the ventilator.

f) If respiratory movements are absent and arterial pCO_2 is $>$ 60 mm Hg (option: 20 mm Hg increase in pCO_2 over a baseline normal pCO_2), the apnea test result is positive (i.e., it supports the diagnosis of brain death).

g) If respiratory movements are observed, the apnea test result is negative (i.e., it does not support the clinical diagnosis of brain death), and the test should be repeated.

h) Connect the ventilator if, during testing, the systolic blood pressure becomes $\leq$ 90 mm Hg or the pulse oximeter indicates significant oxygen desaturation and cardiac arrhythmias are present; immediately draw an arterial blood sample and analyze arterial blood gas. If pCO_2 is $\geq$ 60 mm Hg or pCO_2 increase is $<$ 20 mm Hg over baseline normal pCO_2, the result is indeterminate, and an additional confirmatory test can be considered.

C. Brain Death Declaration in Patients Who Cannot Be Examined.

In patients who cannot be examined to determine brain death because of severe injuries to the face and head or because of high levels of sedative drugs, brain death can be declared after a cerebral arteriogram or isotope cerebral blood flow study demonstrates unequivocally there is no blood flow to the brain. This study must be read by two (2) radiologists certified in the interpretation of cerebral blood flow studies.

II. Pitfalls in the diagnosis of brain death

The following conditions may interfere with the clinical diagnosis of brain death, so that the diagnosis cannot be made

with certainty on clinical grounds alone. Confirmatory tests are recommended.

A. Severe facial trauma

B. Preexisting pupillary abnormalities

C. Toxic levels of any sedative drugs, aminoglycosides, tricyclic antidepressants, anti-cholinergics, antiepileptic drugs, chemotherapeutic agents, or neuromuscular blocking agents

D. Sleep apnea or severe pulmonary disease resulting in chronic retention of CO_2

E. Pregnancy is a special situation

III. Clinical observations compatible with the diagnosis of brain death

These manifestations are occasionally seen and should not be misinterpreted as evidence for brainstem function.

A. Spontaneous movements of limbs other than pathologic flexion or extension response

B. Respiratory-like movements (shoulder elevation and adduction, back arching, intercostals expansion without significant tidal volumes)

C. Sweating, blushing, tachycardia

D. Normal blood pressure without pharmacologic support or sudden increases in blood pressure

E. Absence of diabetes insipidus

F. Deep tendon reflexes; superficial abdominal reflexes; triple flexion response

G. Babinski reflex

IV. Confirmatory laboratory tests (options)

Brain death is a clinical diagnosis. A repeat clinical evaluation 6 hours later is recommended, but this interval is arbitrary. A confirmatory test is not mandatory but is desirable in patients in whom specific components of clinical testing cannot be reliably performed or evaluated. It should be emphasized that any of the suggested confirmatory tests may produce similar results in patients with catastrophic brain damage who do not (yet) fulfill the clinical criteria of brain death. The following confirmatory test findings are listed in the order of the most definitive test first. Consensus criteria are identified by individual tests.

A. Conventional angiography. No intracerebral filling at the level of the carotid bifurcation or circle of Willis. The external carotid circulation is patent, and filling of the superior longitudinal sinus may be delayed.

B. Electroencephalography. No electrical activity during at least 30 minutes of recording that adheres to the minimal technical criteria for EEG recording in suspected brain death as adopted by the American Electroencephalographic Society, including 16-channel EEG instruments.

C. Transcranial Doppler ultrasonography

1. Ten percent of patients may not have temporal insonation windows. Therefore, the initial absence of Doppler signals cannot be interpreted as consistent with brain death.
2. Small systolic peaks in early systole without diastolic flow or reverberating flow, indicating very high vascular resistance associated with greatly increased intracranial pressure.

D. Technetium-99m hexamethylpropyleneamineoxime (HMPAO or Ceretec) or Technetium 99m (ethyl cysteinate dimmer (ECD, Bicisate or Neurolite) brain perfusion scintigraphy; otherwise known as isotope flow study with brain scan. No flow to brain and no uptake of isotope in brain parenchyma (hollow skull phenomenon) is consistent with brain death.

E. Somatosensory evoked potentials. Bilateral absence of N20-P22 response with median nerve stimulation. The recordings should adhere to the minimal technical criteria for somatosensory evoked potential recording in suspected brain death as adopted by the American Electroencephalographic Society.

V. Medical record documentation (standard)

A. Etiology and irreversibility of condition

B. Absence of brainstem reflexes

C. Absence of motor response to pain

D. Absence of respiration with $pCO_2 > 60$ mm Hg

E. Justification for confirmatory test and result of confirmatory test

F. Optional: Repeat neurologic examination. The interval is arbitrary, but a six-hour period is reasonable.

G. Document repeat neurological examination if performed.

See Checklist for Determination of Brain Death on back.

Checklist for Determination of Brain Death in Patients 18 Years of Age or Older in the State of Indiana

Patient's Name: ____________ Room No.: ________ Medical Record No.: ____________

Patient's Age: ________ Sex: Male ☐ Female ☐ Attending Physician: ____________, MD, DO

Has the cause of patient's present neurological state been determined? Yes ☐ No ☐

Have metabolic diseases or toxins been ruled out by history? Yes ☐ No ☐

Exclude: Hypothermia, Hypotension, depressant medication and correctable metabolic imbalance.

Temperature: Fahrenheit ________ or Centigrade ________ Blood Pressure: ____________ mm. Hg

Barbiturate level and Depressant Medication Survey:

Blood drawn: Date: ________ Time: ________ Barbiturate Level: ____________

Significant levels of other depressants: Yes ☐ No ☐

Movements	Present (✓)	Absent (✓)
Spontaneous		
Evoked		
Pectoral pinch		
Pressure on supraciliary ridge		
Pressure on sternum		
Pressure on tibia		

Reflexes	Right Pupil		Left Pupil	
Pupils – Size:	mm.		mm.	
	Yes (✓)	No (✓)	Yes (✓)	No (✓)
Reaction to light				
Reaction to facial pinch				
Corneal Reflex				

	Right Eye		Left Eye	
	Yes (✓)	No (✓)	Yes (✓)	No (✓)
Response to head turning (Doll's Eye Maneuver)				
Response to ice water stimulation (50 ml. each ear 3 min. apart)				

Pontomedullary Reflexes	Yes (✓)	No (✓)
1. Chewing movements		
2. Tongue movements		
3. Gag reflex		
4. Jaw jerk		
5. Response to loud noise		

Apnea Test Patient's temperature must be at least 36.5° C (97° F) to perform this test.		Any Breath Taken Yes (✓)	Any Breath Taken No (✓)
1st Date ________ Time			
Arterial pCO_2 before disconnection			
Arterial pCO_2 after disconnection			
2nd Date (if needed) ________ Time			
Arterial pCO_2 before disconnection			
Arterial pCO_2 after disconnection			

CONFIRMATORY TESTS, if needed – Results

Is the patient brain dead? Yes ☐ (✓) No ☐ (✓)

Date: ________ Time: ________ Signed: ____________, MD, DO

Pediatric Brain Death Diagnostic Criteria – 37 Weeks Gestational Age to 18 Years of Age

Only qualified physicians caring for seriously ill ~~neonatal~~ patients under one year of age should establish brain death in patients under one year of age.

Issues to be considered and protocol to be followed relating to brain death examination:

1. Determination of brain death in neonates, infants, and children relies on a clinical diagnosis that is based on the absence of neurologic function with a known irreversible cause of coma. Coma and apnea must coexist to diagnose brain death. This diagnosis should be made by physicians who have evaluated the history and completed the neurologic examinations.

2. Prerequisites for initiating a brain death evaluation:
   a. Hypotension, hypothermia, and metabolic disturbances that could affect the neurologic examination must be corrected before examination for brain death.
   b. Sedatives, analgesics, neuromuscular blockers, and anticonvulsant agents should be discontinued for a reasonable time period based on elimination half-life of the pharmacologic agent to ensure they do not affect the neurological examination. Knowledge of the total amount of each agent (mg/kg) administered since hospital admission may provide useful information concerning the risk of continued medication effects. Blood or plasma levels to confirm high or supratherapeutic levels of anticonvulsants with sedative effects that are not present should be obtained (if available) and repeated as needed or until the levels are in the low to midtherapeutic range. See Medications sheet, Appendix A.
   c. The diagnosis of brain death based on neurologic examination alone should not be made if supratherapeutic or high therapeutic levels of sedative agents are present. When levels are in the low or in the midtherapeutic range, medication effects sufficient to affect the results of the neurologic examination are unlikely. If uncertainty remains, an ancillary study should be performed. In patients who cannot be examined, refer to # 6 of Physical Examination To Determine Brain Death section in the Guidelines For the Determination of Brain Death in Infants and Children in the State of Indiana.
   d. Assessment of neurologic function may be unreliable immediately after cardiopulmonary resuscitation or other severe acute brain injuries and evaluation for brain death should be deferred for a minimum of 24 hours if there are concerns or inconsistencies in the examination.
   e. In any patient who has a recorded core body temperature of 34 ° C or less, prior to or during hospitalization, a cerebral blood flow study must be performed which shows no cerebral blood flow before brain death can be declared by physical examination. A core body temperature of 35° C or greater should be maintained for at least 24 hours prior to initiating brain death examinations.

3. Number of examinations, examiners, and observation periods:
   a. Two examinations including apnea testing with each examination separated by an observation period are required.
   b. The examinations should be performed by different attending physicians involved in the care of the child. The apnea test may be performed by the same physician, preferably the attending physician who is managing ventilator care of the child.
   c. Recommended observation periods:
      1. Twenty-four hours for neonates (37 weeks gestation to term infants 30 days of age)
      2. Twelve hours for infants and children (>30 days to 18 years)

d. The first examination determines the child has met neurologic examination criteria for brain death. The second examination, performed by a different attending physician, confirms that the child has fulfilled criteria for brain death.
e. Physicians attesting to brain death cannot be part of the organ procurement team.

4. Apnea testing:
   a. Apnea testing must be performed safely and requires documentation of an arterial $Paco_2$ 20 mm Hg above the baseline $Paco_2$ and $\geq$ 60 mm Hg with no respiratory effort during the testing period to support the diagnosis of brain death. Some infants and children with chronic respiratory disease or insufficiency may only be responsive to supranormal $Paco_2$ levels. In this instance, the $Paco_2$ level should increase to $\geq$ 20 mm Hg above the baseline $Paco_2$ level.
   b. If the apnea test cannot be performed as a result of a medical contraindication or cannot be completed because of hemodynamic instability, desaturation to <85%, or an inability to reach a $Paco_2$ of $\geq$ 60 mm Hg, an ancillary study should be performed.

5. Ancillary studies:
   a. Ancillary studies (electroencephalography, cerebral angiography, and radionuclide cerebral blood flow) are not required to establish brain death unless the clinical examination or apnea test cannot be completed.
   b. Radionuclide cerebral blood flow study must be performed with a lipophilic isotope. Both dynamic and static phases of the study must be performed. Two of these isotopes available in the United States are:
      1. Technetium – 99m hexamethylpropylene-amineoxime (HMPAO or Ceretec)
      2. Technetium – 99m ethyl cysteinate dimer (ECD, Bicisate, or Neurolite)
   c. An EEG (electroencephalogram) demonstrating electrocerebral silence in the absence of other causative factors (i.e. drugs) is supportive of brain death.
   d. Ancillary studies are not a substitute for the neurologic examination.
   e. It must be recognized that both EEG and cerebral blood flow studies are less sensitive and less reliable in infants <30 days of age. A cerebral blood flow may be preferred over EEG in this age group.
   f. For all age groups, ancillary studies can be used to assist the clinician in making the diagnosis of brain death to reduce the observation period or when 1) components of the examination or apnea testing cannot be completed safely as a result of the underlying medical condition of the patient; 2) if there is uncertainty about the results of the neurologic examination; or 3) if a medication effect may interfere with evaluation of the patient. If the ancillary study supports the diagnosis, the second examination and apnea testing can then be performed. When an ancillary study is used to reduce the observation period, all aspects of the examination and apnea testing should be completed and documented.
   g. When an ancillary study is used because there are inherent examination limitations (i.e., 1-3 in 5d), then components of the examination done initially should be completed and documented.
   h. If the ancillary study is equivocal or if there is concern about the validity of the ancillary study, the patient cannot be pronounced dead. The patient should continue to be observed until brain death can be declared on clinical examination criteria and apnea testing or a follow-up ancillary study can be performed to assist with the determination of brain death. A waiting period of 24 hours is recommended before further clinical re-evaluation or repeat ancillary study is performed. Supportive patient care should continue during this time period.

6. Declaration of death
   a. The time of death is declared after the second clinical examination and apnea test are completed and confirm brain death.
   b. When ancillary studies are used, documentation of components from the second clinical examination that can be completed must remain consistent with brain death. All aspects of the clinical examination, including the apnea test, or ancillary studies must be appropriately documented.

PHYSICAL EXAMINATION TO DETERMINE BRAIN DEATH

Reversible conditions or conditions that can interfere with the neurologic examination must be excluded before brain death testing.

1. **Coma**.
   The patient must exhibit complete loss of consciousness, vocalization, and volitional activity.
   Patients must lack all evidence of responsiveness. Eye opening or eye movement to noxious stimuli is absent.
   Noxious stimuli should not produce a motor response other than spinally mediated reflexes. The clinical differentiation of spinal responses from retained motor responses associated with brain activity requires expertise.

2. **Loss of all brain stem reflexes, including:**
   Midposition or fully dilated pupils which do not respond to light.
   Absence of pupillary response to a bright light is documented in both eyes.
   Usually the pupils are fixed in a midsize or dilated position (4-9mm).
   When uncertainty exists, a magnifying glass should be used.
   Absence of movement of bulbar musculature including facial and oropharyngeal muscles.
   Deep pressure on the condyles at the level of the temporomandibular joints and deep pressure at the supraorbital ridge should produce no grimacing or facial muscle movement.
   Absent gag, cough, sucking, and rooting reflex.
   The pharyngeal or gag reflex is tested after stimulation of the posterior pharynx with a tongue blade or suction device. The tracheal reflex is most reliably tested by examining the cough response to tracheal suctioning. The catheter should be inserted into the trachea and advanced to the level of the carina followed by one or two suctioning passes.
   Absent corneal reflexes.
   Absent corneal reflex is demonstrated by touching the cornea with a piece of tissue paper, a cotton swab, or squirts of water. No eyelid movement should be seen. Care should be taken not to damage the cornea during testing.
   Absent oculovestibular reflexes.
   The oculovestibular reflex is tested by irrigating each ear with ice water (caloric testing) after the patency of the external auditory canal is confirmed. The head is elevated to 30 degrees. Each external auditory canal is irrigated (one ear at a time) with approximately 10-50mL of ice water. Movement of the eyes should be absent during 1 minute of observation. Both sides are tested with a minimum interval of five (5) minutes.

3. Apnea.

The patient must have the complete absence of documented respiratory effort (if feasible) by formal apnea attesting demonstrating a $Paco_2 \geq 60$ mm Hg and $\geq$ 20 mm Hg increase above baseline.

Normalization of the pH and $Paco_2$ measured by arterial blood gas analysis, maintenance of core temperature >35°C, normalization of blood pressure appropriate for the age of the child, and correcting for factors that could affect respiratory effort are a prerequisite to testing.

The patient should be preoxygenated using 100% oxygen for 5-10 minutes before initiating this test.

Intermittent mandatory mechanical ventilation should be discontinued once the patient is well oxygenated and a normal $Paco_2$ has been achieved.

The patient's heart rate, blood pressure, and oxygen saturation should be continuously monitored while observing for spontaneous respiratory effort throughout the entire procedure.

Follow-up blood gases should be obtained at 5-10 minute intervals to monitor the rise in $Paco_2$ while the patient remains disconnected from mechanical ventilation.

If no respiratory effort is observed from the initiation of the apnea test to the time the measured $Paco_2 \geq 60$ mm Hg and $\geq$ 20 mm Hg above the baseline level, the apnea test is consistent with brain death.

The patient should be placed back on mechanical ventilator support and medical management should continue until the second neurologic examination and apnea test confirming brain death is completed.

If oxygen saturations fall <85%, hemodynamic instability limits completion of apnea testing, or a $Paco_2$ level of $\geq$ 60 mm Hg cannot be achieved, the infant or child should be placed back on ventilator support with appropriate treatment to restore normal oxygen saturations, normocarbia, and hemodynamic parameters. Another attempt to test for apnea may be performed at a later time or an ancillary study may be pursued to assist with determination of brain death.

Evidence of any respiratory effort is inconsistent with brain death and the apnea test should be terminated.

4. Flaccid tone and absence of spontaneous or induced movements, excluding spinal cord events such as reflex withdrawal or spinal myoclonus.

The patient's extremities should be examined to evaluate tone by passive range of motion assuming that there are no limitations to performing such an examination (e.g., previous trauma, etc.) and the patient observed for any spontaneous or induced movements.

If abnormal movements are present, clinical assessment to determine whether these are spinal cord reflexes should be done.

5. Brain Death Declaration.

After the second physical examination demonstrates no brain life, the patient is brain dead and is to be declared brain dead at that time.

6. Brain Death Declaration in Patients Who Cannot be Examined

In patients who cannot be examined to determine brain death because of severe injuries to the face and head or because of high levels of sedative drugs, brain death can be declared after a cerebral arteriogram or isotope cerebral blood flow study demonstrates unequivocally no blood flow to the brain. This study must be read by two (2) radiologist certified in the interpretation of cerebral blood flow studies.

DRUG ELIMINATION TABLE TO SERVE AS REFERENCE FOR PRACTITIONERS WHEN DEALING WITH PATIENTS RECEIVING SPECIFIC PHARMACOLOGICAL AGENTS AND WHO ARE UNDERGOING BRAIN DEATH TESTING

Appendix A

MEDICATIONS ADMINISTERED TO CRITICALLY ILL PEDIATRIC PATIENTS AND RECOMMENDATIONS FOR TIME INTERVAL TO TESTING AFTER DISCONTINUATION OF MEDICATIONS

Medication	Infants/Children Elimination Half-Life	Neonates Elimination Half-Life
Intravenous induction, anesthetic, and sedative agents		
Thiopental	Adults: 3-11.5 hrs (shorter half life in children)	
Ketamine	2.5 hrs	
Etimodate	2.6-3.5 hrs	
Midazolam	2.9-4.5 hrs	4-12 hrs
Propofol	2-8 mins, terminal half-life 200 mins (range, 300-700 mins)	
Dexmedetomidine	Terminal half-life 83-159 mins	Infants have faster clearance
Antiepileptic drugs		
Phenobarbital	Infants: 20-133 hrs* Children 37-73 hrs*	45-500 hrs*
Pentobarbital	25 hrs*	
Phenytoin	11-55 hrs*	63-88 hrs*
Diazepam	1 mo. to 2 yrs: 40-50 hrs 2-12 yrs: 15-21 hrs 12-16 yrs: 18-20 hrs	50-95 hrs
Lorazepam	Infants: 40.2 hrs (range 18-73 hrs) Children: 10.5 hrs (range 6-17 hrs)	40 hrs
Clonazepam	22-33 hrs	
Valproic acid	Children >2 months: 7-13 hrs* Children 2-14 yrs: mean 9 hrs; range, 3.5-20 hrs	10-67 hrs*
Levetiracetam	Children 4-12 yrs: 5 hrs	
Intravenous narcotics		
Morphine sulfate	Infants 1-3 months: 6.2 hrs (5-10 hrs) 6 months to 2.5 yrs: 2.9 hrs (1.4-7.8 hrs) Children: 1-2 hrs	7.6 hrs (range, 4.5-13.3 hrs)
Meperidine	Infants <3 months: 8.2-10.7 hrs (range, 4.9-31.7 hrs); Infants 3-18 months: 2.3 hrs Children: 5-8 yrs: 3 hrs	23 hrs (range, 12-39 hrs)
Fentanyl	5 months to 4.5 yrs: 2.4 hrs (mean); 0.5-14 yrs: 21 hrs (range, 11-36 hrs for long-term infusions)	1-15 hrs
Sufentanil	Children 2-8 yrs: 97 + 42 mins	382-1,162 mins
Muscle relaxants		
Succinylcholine	5-10 mins; prolonged duration of action in patients with pseudocholinesterase deficiency or mutation	
Pancuronium	110 mins	
Vecuronium	41 mins	65 mins
Atracurium	17 mins	20 mins
Rocuronium	3-12 months: 1.3 $\pm$ 0.5 hrs 1 to <3 yrs: 1.1 $\pm$ 0.7 hrs 3 to <8 yrs: 0.8 $\pm$ 0.3 hrs Adults: 1.4-2.4 hrs	

*Elimination half-life does not guarantee therapeutic drug levels for longer-acting medications or medications with active metabolites. Drug levels should be obtained to ensure that levels are in a low to midtherapeutic range before neurologic examination to determine brain death. In some instances, this may require waiting several half-lives and rechecking serum levels of the medication before conducting the brain death examination.

Metabolism of pharmacologic agents may be affected by organ dysfunction, age, patient condition, and hypothermia. Physicians should be aware of total amounts of administered medication that can affect drug metabolism and levels.

Checklist for Documentation of Brain Death in Infants and Children

Two physicians must perform independent examinations separated by specified intervals.

Age of Patient	Timing of First Exam	Inter-exam, Interval
Term newborn 37 weeks gestational age and up to 30 days old	☐ First exam may be performed 24 hours after birth OR following cardiopulmonary resuscitation or other severe brain injury.	☐ At least 24 hours ☐ Interval shortened because ancillary study (Section 4) is consistent with brain death
31 days to 18 years	☐ First exam may be performed 24 hours following cardiopulmonary resuscitation or other severe brain injury	☐ At least 12 hours OR ☐ Interval shortened because ancillary study (Section 4) is consistent with brain death

Section 1. PREREQUISITES for brain death examination and apnea test

A. IRREVERSIBLE AND IDENTIFIABLE Cause of Coma (Please check)

☐ Traumatic brain injury ☐ Anoxic brain injury ☐ Known metabolic disorder ☐ Other (specify)

	B. Correction of contributing factors that can interfere with the neurologic examination	Examination One		Examination Two	
a.	Core body temp is over 95°F (35°C)	☐ Yes	☐ No	☐ Yes	☐ No
b.	Systolic blood pressure or MAP in acceptable range (systolic BP not less than 2 standard deviations below age appropriate norm) based on age	☐ Yes	☐ No	☐ Yes	☐ No
c.	Sedative/analgesic drug effect excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No
d.	Metabolic intoxication excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No
e.	Neuromuscular blockade excluded as a contributing factor	☐ Yes	☐ No	☐ Yes	☐ No

☐ If ALL prerequisites are marked YES, then proceed to Section 2, OR

☐ Confounding variable was present. Ancillary study was therefore performed to document brain death (Section 4)

	Section 2. Physical Examination (Please check) **Note: SPINAL CORD REFLEXES ARE ACCEPTABLE.**	Examination One Date / Time		Examination Two Date / Time	
a.	Flaccid tone, patient unresponsive to deep painful stimuli	☐ Yes	☐ No	☐ Yes	☐ No
b.	Pupils are midposition or fully dilated and light reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
c.	Corneal, cough, gag reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
	Sucking and rooting reflexes are absent (in neonates and infants)	☐ Yes	☐ No	☐ Yes	☐ No
d.	Oculovestibular reflexes are absent	☐ Yes	☐ No	☐ Yes	☐ No
e.	Spontaneous respiratory effort while on mechanical ventilation is absent	☐ Yes	☐ No	☐ Yes	☐ No

☐ The _______________*(specify)* element of the exam could not be performed because____________________

Ancillary study (EEG or radionuclide (CBF) was therefore performed to document brain death (Section 4).

Section 3. APNEA Test	Examination One Date / Time	Examination Two Date / Time
No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq$ 60 mm Hg and a $\geq$ 20 mm Hg increase above baseline. (Examination One)		
No spontaneous respiratory efforts were observed despite final $PaCO_2 \geq$ 60 mm Hg and a $\geq$ 20 mm Hg increase above baseline. (Examination Two)		

Apnea test is contraindicated or could not be performed to completion because ________________________

Ancillary study (EEG or radionuclide CBF) was therefore performed to document brain death (Section 4).

Section 4. ANCILLARY testing	Date / Time
Ancillary testing is required when: 1. Any components of the examination or apnea testing cannot be completed; 2. If there is uncertainty about the results of the neurologic examination; or 3. If a medication effect may be present. Ancillary testing can be performed to reduce the inter-examination period; however, a second neurologic examination is required. Components of the neurologic examination that can be performed safely should be completed in close proximity to the ancillary test.	
☐ Electroencephalogram (EEG) report documents electrocerebral silence OR	☐ Yes ☐ No
☐ Cerebral Blood Flow (CBF) study report documents no cerebral perfusion	☐ Yes ☐ No

Section 5. Signatures

Examiner One

I certify that my examination is consistent with cessation of function of the brain and brainstem. Confirmatory exam to follow.

(Printed Name) (Signature)

(Specialty) (Pager # /License # (Date mm/dd/yyyy) (Time)

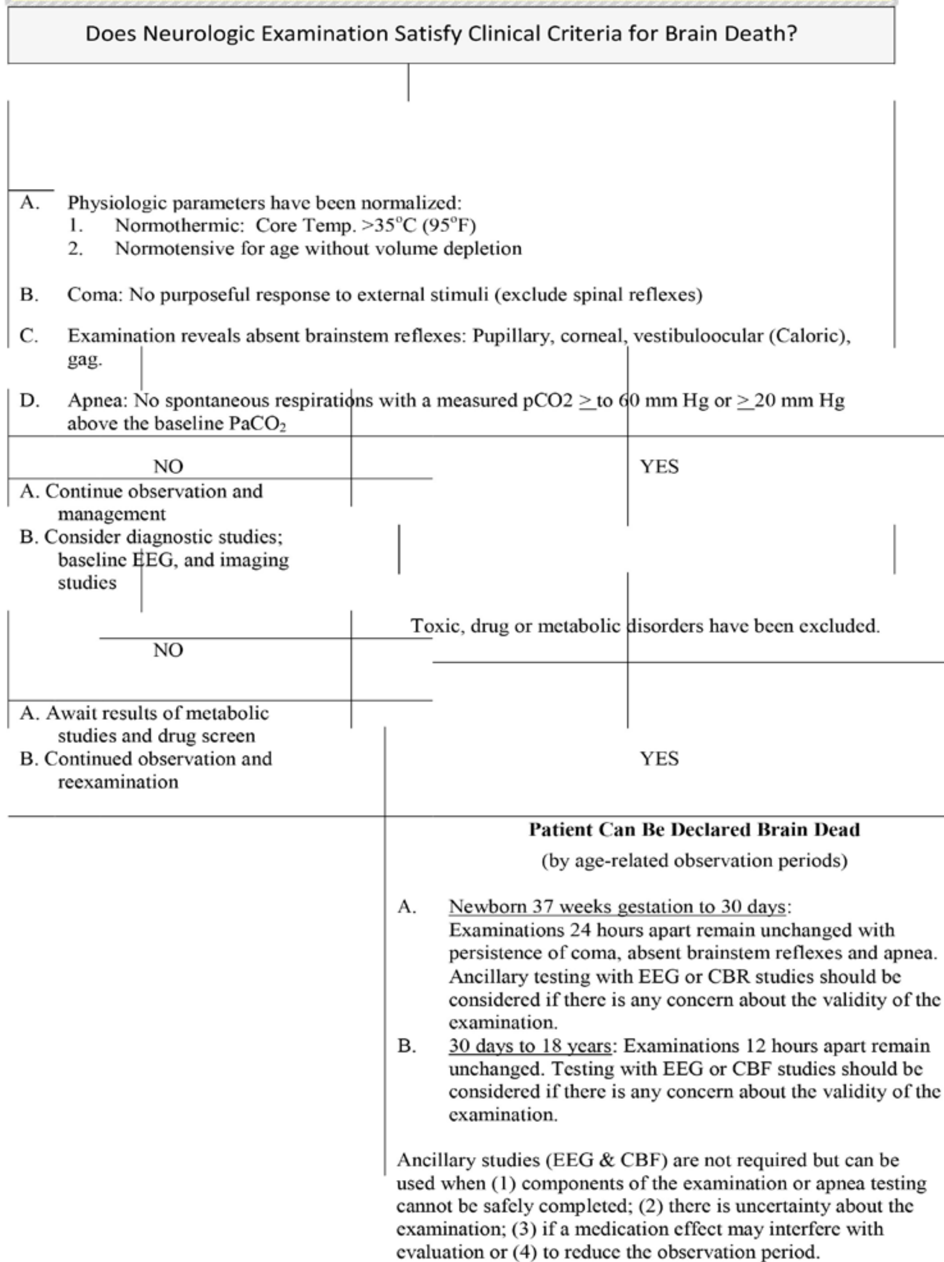
Examiner Two

I certify that my examination ☐ and/or ancillary test report ☐ confirms unchanged and irreversible cessation of function of the brain and brainstem. The patient is declared brain dead at this time.

Date/Time of death: ________________

(Printed Name) (Signature)

(Specialty) (Pager # /License # (Date mm/dd/yyyy) (Time)



The content of these Brain Death Guidelines is largely excerpted from an article published in *Critical Care Medicine* 2011 Vol. 39, No. 9, entitled "Guidelines for the determination of brain death in infants and children; An update of the 1987 Task Force recommendations." For documentation and supportive information, including an extensive bibliography, please refer to the aforementioned publication.

(RESOLUTION 15-02) RESOLVED, that the ISMA seek legislation and support efforts to change Indiana's Surrogate Consent Statute § 16-36-1-5-(a)(2) that:

- Provides a more inclusive list of eligible individuals who can serve as surrogate decision makers
- Establishes a hierarchy or dispute resolution process for cases in which more than one legal surrogate is present and they cannot agree on patient care; and be it further

RESOLVED, that the ISMA delegation ask the AMA to support a surrogate consent statute that:

- Provides a more inclusive list of eligible individuals who can serve as surrogate decision makers
- Establishes a hierarchy or dispute resolution process for cases in which more than one legal surrogate is present and they cannot agree on patient care.

(RESOLUTION 12-02) RESOLVED, that the ISMA adopt the attached guidelines for the Determination of Brain Death in Infants and Children, and the Checklist for Infants and Children for use in Indiana medical facilities. (Find the guidelines at www.ismanet.org/convention/2012/Peds-Death-Guidelines.pdf.)

DIETARY SUPPLEMENTS

(RESOLUTION 09-06) RESOLVED, that the ISMA delegation to the AMA introduce a resolution at the AMA 2010 House of Delegates meeting encouraging passage of legislation that would lead to government supervision to ensure content and purity of over-the-counter supplements, while continuing to otherwise support the Dietary Supplement Health and Education Act passed by Congress that does not evaluate product safety or efficacy.

DRIVING – SAFETY

(RESOLUTION 17-38) RESOLVED, the ISMA send this resolution to the AMA House of Delegates for consideration with the recommendation that it is referred to the Council of Science and Public Health for study, and report back to the House of Delegates; and be it further
RESOLVED, ISMA ask the AMA to study the safety risks to drivers and their passengers when they approach vehicles with incandescent, xenon gas or LED headlights as well as the use of other technologies such as automated steering and automated windshield tinting to mitigate the risk; and be it further
RESOLVED, the ISMA ask the AMA to advocate for mandatory automated high-beam to low-beam headlight switching systems that would operate when an approaching vehicle head light is detected.

(READOPTED RESOLUTION 17-13, READOPTED RESOLUTION 07-29A, RESOLUTION 97-51) RESOLVED, that ISMA work with all groups to educate the public about the hazards of using a cell phone and electronic messaging while driving; and be it further
RESOLVED, that ISMA work with groups trying to create legislation to make using a hand-held cell phone and electronic text messaging while driving a fineable offense and support such legislation to the extent supported by scientific data, with appropriate exemptions for law enforcement, public safety workers and medical professionals

(RESOLUTION 17-09) RESOLVED, that ISMA promote educational efforts against impaired driving, including operating a passenger vehicle in Indiana with a blood alcohol concentration (BAC) of 0.04 percent or greater.

(READOPTED & AMENDED 11-21, HOD; RESOLUTION 01-13) RESOLVED, that the ISMA continue to support efforts to ban hand-held two-way electronic telecommunications devices from use while driving, excluding those used by federally licensed radio services, and public safety and law enforcement personnel to carry out work-related responsibilities, and drivers calling 911 or other entities in urgent or emergency situations.

(READOPTED 10-60, HOD; RESOLUTION 00-01) RESOLVED, that the ISMA continue to support graduated licensing requirements for young drivers consistent with recommendations from the National Highway Traffic Safety Administration.

(RESOLUTION 09-12) RESOLVED, that the ISMA support state and federal legislation, policy, rules and regulations to prohibit the use of handheld wireless telephonic communication devices while driving. This would not prohibit the use of handheld wireless telephonic communications devices in hands-free mode nor in emergency situations nor by users authorized to conduct such communications by the Federal Communications Commission or the National Telecommunications and Information Administration.

(3/75, BOT) That physicians be willing to submit data and do physical examinations for third parties but not be responsible for judging a person's insurability or ability to drive.

DRUG ABUSE

(RESOLUTION 17-36) RESOLVED, that ISMA support expanding naloxone training for the lay population in order to decrease the risk of fatal overdose. Additionally, the training program and naloxone supply that is funded by the Indiana State Department of Health should be expanded to provide two separate doses of naloxone because of the risk posed by fentanyl and carfentanyl with overdose relapse; and be it further
RESOLVED, that ISMA support the continuing availability of over-the-counter naloxone either through order by the Indiana State Health Commissioner or legislative action; and be it further
RESOLVED, that the ISMA support the expansion of programs linking users of Naloxone for the purpose of reversing opioid overdose to long-term addictions management; and be it further
RESOLVED, that the AMA be asked to study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions).

(RESOLUTION 17-35) RESOLVED, the ISMA support increased funding for inpatient and outpatient treatment of drug addiction; and be it further
RESOLVED, ISMA support the establishment of a mandatory registry that contains inpatient bed census data so that available inpatient drug-addiction treatment beds would be easily identifiable. This would enhance the speed of treatment and provide a more efficient use of inpatient resources. It is expected that these facilities would readily accept these patients from more distant locations.

(RESOLUTION 16-38) RESOLVED, that the ISMA ask the Indiana legislature to strongly promote and fund an anti-drug campaign across the state, including an anti-drug curriculum for grade schools that has proven effective in promoting primary prevention; other measures are:

- Expanding awareness, education and funding for Narcan use by laypersons and first responders in order to help mitigate overdose deaths
- Enhancing drug interdiction efforts
- Enhancing funding for drug addiction therapy, both outpatient and inpatient, but especially for inpatient programs (Tobacco settlement funds could help fund part of this program.)
- Support and fund validated programs that begin drug rehabilitation while incarcerated and while on probation; and be it further

RESOLVED, that the ISMA strongly support the development of mandatory, age-appropriate evidenced-based drug (specifically to include opiates) education for Indiana students and interested parties.

(RESOLUTION 16-34) RESOLVED, that the ISMA and the AMA support the requirement that medical facility needle/syringe disposal devices be as theft-proof and tamper-proof as possible; this requirement could be established by rule or by statute; and be it further
RESOLVED, that the ISMA and AMA support the requirement that stored used needles/syringes be properly secured so as to discourage theft; and be it further

RESOLVED, that the ISMA and the AMA support the requirement that theft and tamper-proof containers be placed in public restrooms for the purpose of needle/syringe disposal; an ideal device would crush the syringe as part of the disposal process; and be it further
RESOLVED, that the ISMA and AMA encourage those communities with a significant IV drug abuse population to establish a needle exchange program, since this helps eliminate the demand for used needles/syringes; and be it further
RESOLVED, that Resolution 16-34 be forwarded to the AMA for consideration if adopted by the ISMA.

(RESOLUTION 16-04) RESOLVED, that the ISMA actively support a coordinated drug and alcohol program funded by the state for treatment of inmates in local jails to help stop the current recycling of inmates who, upon release, return to their old habits of drug and alcohol use.

(RESOLUTION 15-51) RESOLVED, that the ISMA support federal legislative efforts to curb the growing prescription drug and heroin abuse epidemics through the following efforts:

- Develop best practices in pain medication prescribing and related pain management
- Develop the National All Schedules Prescription Electronic Reporting system (NASPER)
- Support federal assistance for programs that specialize in prevention and drug treatment programs
- Increase the education and preparedness of local first responders to administer Naloxone to overdose patients
- Support state and national education programs that focus attention on the link between prescription drug abuse and heroin use.

(RESOLUTION 15-46) RESOLVED, that the ISMA discourage the over-use of extended-release opioids and when prescribed, an abuse-deterrent formulation should be utilized for the treatment of chronic non-cancer related pain.

(RESOLUTION 15-29) RESOLVED, that the ISMA seek and support legislation consistent with the following statement: "The results of prenatal verbal screening for substance use and toxicology screening shall be confidential and shall not be released or disclosed to anyone, including any local state or federal agency for any reason other than medical care or data analysis of high risk and at-risk pregnancies for planning purposes by public health officials," and that the ISMA collaborate with the ISDH and any other interested parties in support of such legislation.

(RESOLUTION 15-01) RESOLVED, that the ISMA encourage the voluntary use of a document such as the *Advance Directive for Addiction in Remission and to Ensure Continued Recovery* to facilitate communication between patients with a history of opiate addiction and physicians prior to an event (e.g. surgery) requiring the use of medications with addictive potential.

(RESOLUTION 14-35) RESOLVED, that the ISMA support both public and physician education on the physical and mental impact of chronic marijuana smoking from the NIDA including their just-published review in *The New England Journal of Medicine* (June 4, 2014); and be it further
RESOLVED, that if funding is available, the ISMA should promote and/or disseminate the National Institute on Drug Abuse pamphlet "Marijuana Facts for Teens."

(RESOLUTION 12-26A) RESOLVED, that the ISMA seek and support methods to reduce the sale of products containing dextromethorphan to minors; and be it further
RESOLVED, that the ISMA request the AMA to also seek and support methods to reduce the sale of products containing dextromethorphan to minors.

EMERGENCIES, MEDICAL

(RESOLUTION 14-28) RESOLVED, that the ISMA support that when providing advanced cardiac life support, advanced trauma life support, advanced pediatric life support and other similar emergencies, health care

facilities should maintain up-to-date suggested algorithms electronically or on paper to ensure that this information is readily accessible during the medical emergency; and be it further
RESOLVED, that the ISMA support that health care facilities should have a policy of providing a qualified person that the physician can designate to present the suggested algorithm during the active treatment; and be it further
RESOLVED, that this resolution be sent to the American Medical Association (AMA) for consideration.

(RESOLUTION 14-13) RESOLVED, that the ISMA continues to work with the Indiana State Department of Health, Homeland Security, the American College of Surgeons and interested parties toward the goal of a statewide trauma care system for Indiana; and be it further
RESOLVED, that the ISMA continue to encourage hospitals and physicians wherever they are credentialed to be involved in trauma care; and be it further
RESOLVED, that the ISMA work with the American College of Surgeons and interested parties with legislative input to seek funding crucial to the complete implementation and maintenance of a statewide trauma care system.

(RESOLUTION 11-53) RESOLVED, that the ISMA seek legislation recognizing Physician Orders for Life Sustaining Treatment (POLST) as a standing, immediately actionable medical order transferable across medical settings (example POLST form attached).

(READOPTED 11-12, HOD; RESOLUTION 01-18) RESOLVED, that the ISMA continue to support efforts requiring all EMTs to be trained and authorized to appropriately administer epinephrine to patients under the age of 18 for all anaphylactic reactions.

(RESOLUTION 08-37) RESOLVED, that the ISMA support state legislation as well as federal requiring all facilities in Indiana rendering emergency care to provide on-site, comprehensive services to sexual assault patients in accordance with widely accepted standards of care, without exemption for sectarian reason. Such services must include all the following:

- Treatment of trauma
- Testing and prophylaxis for sexually transmitted disease
- Collection of forensic evidence
- On-site availability of emergency contraception for patients capable of pregnancy
- Information and written materials about a patient's right to emergency contraception. Information shall be scientifically accurate, factual and objective. It shall be clearly written and readily comprehensible in a culturally competent manner. It shall explain the nature of emergency contraception, including its use, safety, efficacy and availability, and shall state that this form of contraception does not cause abortion of an established pregnancy.

(8/11/82, EC) General support for the several emergency medical identification systems (jewelry); however, no endorsement for any particular manufacturer.

(8/15/79, EC) Discourages the use of hospital emergency rooms for non-emergency problems.

ENVIRONMENT

(RESOLUTION 16-32) RESOLVED, that the ISMA issue a statement officially recognizing that pollution and environmental factors contribute to public health morbidity and mortality.

(RESOLUTION 14-19, BOT) Accepted as a resource the AMA's environmental policies as follows: H135.949 Support of Clean Air and Power Plan Emissions Act; H135.973 Stewardship of the Environment; H135.991 Clean Air and H135.972 Support EPA Regulation of Carbon Pollution.

(RESOLUTION 14-24, BOT) RESOLVED, that the ISMA actively engage in activities and seek leadership opportunities in initiatives concerning environmental exposures and their effects on public health in Indiana with annual reports back to the board and House of Delegates. The ISMA should work to identify physicians involved in these activities and facilitate communication among the groups.

FAMILIES

(RESOLUTION 14-31, BOT) Approved supporting continued ISMA participation in existing groups tasked with reducing infant mortality (Indiana Perinatal Quality Improvement Collaborative and the Collaborative Improvement and Innovation Network) with reports back from board members serving on the committees. Requests should be made to the Indiana State Department of Health for periodic data updates from all appropriate agencies addressing this issue.

FAMILY/DOMESTIC VIOLENCE

(READOPTED 15-17, HOD; RESOLUTION 05-26) RESOLVED, that the ISMA support legislation that designates a child as a "child in need of services" who is a passenger in a vehicle operated by the child's parent, guardian or custodian while that adult is intoxicated.

(READOPTED 14-09, BOT; RESOLUTION 04-19) RESOLVED, that the ISMA support legislation that would increase the severity of penalties for the criminal maltreatment of older adults, making the penalties comparable to that of abuse of a child.

(READOPTED 14-08; RESOLUTION 04-16) RESOLVED, that the ISMA support meaningful domestic violence legislation in the Indiana General Assembly.

(READOPTED 14-07; RESOLUTION 04-15) RESOLVED, that the ISMA encourage the Indiana University School of Medicine and the Marian University College of Osteopathic Medicine to include training on family violence in their curriculums; and be it further,
RESOLVED, that the ISMA provide ongoing education on family violence of physicians in practice and the general public.

(READOPTED 14-06; RESOLUTION 04-14) RESOLVED, that the ISMA recommend the following steps in recognizing and treating victims of family violence:

- Routinely ask specific questions about abuse during the patient's social history, past medical history or history of present illness.
- Ask directly about violence with such questions as, "At any time has a partner hit, kicked or otherwise hurt or frightened you?"
- Interview your patient about these questions in private at all times.
- Document your findings. Information about suspected family violence in the patient's chart can serve a valuable function in court should any patient decide to seek legal redress. A physician's documentation could validate the patient's position.
- Assess your patient's safety before they leave the medical setting.
- Review options with your patient. Know the referral organizations available to patients in your area such as shelters, legal advocacy, counseling and support groups. Provide the patient with local and/or state hotline numbers; and be it further,

RESOLVED, that the ISMA continue to take all reasonable steps to disseminate family violence information to all practicing physicians.

(READOPTED 13-26; RESOLUTION 03-21) RESOLVED, that the ISMA continue to place a high priority on supporting legislative efforts addressing family violence issues.

(READOPTED 13-25; RESOLUTION 03-03) RESOLVED, that the ISMA continue to support legislation that strengthens Indiana laws regarding child abuse and neglect to reflect the national guidelines that place the child's welfare above any rights of parents.

(READOPTED 17-08, READOPTED 07-07, HOD; RESOLUTION 97-17) RESOLVED that the ISMA support and advocate for measures that will strengthen the protection of children and endangered adults from acts of abuse; and be it further,
RESOLVED that the ISMA oppose all state and federal legislation and actions that will in any way hinder, obstruct or weaken the ability of law enforcement agencies to investigate suspected cases of abuse of children and endangered adults.

FINANCIAL FRAUD

(RESOLUTION 11-23) RESOLVED, that the ISMA support, endorse and promote the Elder Investment Fraud and Financial Exploitation Prevention Program through the Securities Commissioner of the Indiana Secretary of State's Office to empower ISMA members in identifying and referring older patients who may be most vulnerable to financial/investment fraud abuse.

FIREARMS

(READOPTED 10-49, HOD; RESOLUTION 00-30A) RESOLVED, that the ISMA advocate educational programs for the responsible use and storage of firearms; advocate comprehensive health education as a means of addressing social issues such as violence and urge incorporation of such health education into our societal framework; support scientific research and objective discussion aimed at identifying causes and finding solutions to the crime and violence problem; and support vigorous enforcement of existing gun laws and support free enjoyment of rights granted under the Constitution to law-abiding citizens.

(RESOLUTION 08-09) RESOLVED, that the ISMA support legislation to require that a statement be provided with the sale of each firearm about the increased risk of suicide associated with bringing a firearm into a home and how that risk can be reduced with safe storage; and be it further,
RESOLVED, that the ISMA support efforts with non-profit organizations for a public awareness campaign on the risk of suicide associated with firearm ownership; and be it further,
RESOLVED, that the ISMA support legislation requiring the Indiana State Department of Health to prepare and publish an annual report on suicide in Indiana based on available data collected by coroners that would include:

- The means used
- Gender, age, race and county of residence of the victim
- Any use of firearms in a suicide
- Whether or not the victim owned the firearm
- How the firearm was stored and obtained.

(RESOLUTION 08-08A) RESOLVED, that the ISMA establish policy recognizing that criminal firearm violence is a major public health problem; and be it further,
RESOLVED, that the ISMA support legislation that would:

- Improve the reporting of felony convictions and mental health commitments to the federal database ; and be it further,

RESOLVED, that the ISMA oppose legislation that prevents schools, hospitals and businesses from restricting the presence of firearms on their property.

(RESOLUTION 08-08B) RESOLVED, that the ISMA support legislation to require the Indiana State Department of Health to provide an annual report on criminal firearm violence in Indiana, including the number, age, race, gender and zip code of victims, circumstances of the incident, type of weapon, and whether the weapon was legally owned by the user and, if not, how it was obtained; and be it further,
RESOLVED, that the ISMA support legislation to change the reporting of deaths by coroners and police to include data on the type and source of firearms involved in injuries and deaths.

FOUNDATIONS/GIFTS

(RESOLUTION 13-23) RESOLVED, that the ISMA become a founding donor to the Indiana MacDougall/Mellinger Honor Fund within the AMA Foundation; and be it further
RESOLVED, that the ISMA allocate $2,000 per year for five years to the Indiana MacDougall/Mellinger Honor Fund.

HEALTH CARE SYSTEM

(RESOLUTION 17-30) RESOLVED, that ISMA support medical competency at health-plan medical-director levels by defining and creating policy that coverage decisions are indeed the practice of medicine and, therefore, subject to all laws and regulations attached to that designation; and be it further

RESOLVED, ISMA seek legislation that requires health-plan medical directors to be physicians with a broad knowledge of medical services, or a physician of the same specialty as the requesting physician (when feasible) to make care determinations impacting patients and practicing physicians.

(READOPTED 15-14, HOD; RESOLUTION 05-16) RESOLVED, that the ISMA support patients' rights to choose their physicians and any proposed legislation supporting these principles.

(RESOLUTION 13-28) RESOLVED, that the ISMA seek legislation requiring physician licensure in Indiana not be conditioned upon or related to physician participation in any public or private insurance plan, public health care system, public service initiative or emergency room coverage.

(RESOLUTION 11-32A) RESOLVED, that the ISMA: recognize that exclusion from civil union or marriage contributes to health care disparities affecting same-sex households; will work to reduce health care disparities among members of same-sex households, including minor children; and will support measures providing same-sex households with the same rights and privileges to health care, health insurance and survivor benefits as afforded opposite-sex households.

(RESOLUTION 10-19) RESOLVED, that the ISMA policy support legislation to encourage physicians, especially those near retirement, to continue to provide care by decreasing liability costs (especially for total charity care); and be it further,
RESOLVED, that the ISMA study ways to help keep senior physicians engaged in the practice of medicine as they near retirement.

(RESOLUTION 10-02A) RESOLVED, that the ISMA:

1. Recognizes that exclusion from civil unions or marriage contributes to health care disparities affecting same-sex households;
2. Will work to reduce health care disparities among members of same-sex households, including minor children; and
3. Will support measures providing same-sex households with the same rights and privileges to health care, health insurance and survivor benefits, as afforded opposite-sex households.

(RESOLUTION 09-67) RESOLVED, that the attached set of principles be a starting point for the discussion to establish the ISMA's position on health reform; and be it further,
RESOLVED, that the ISMA supports:

- Extending coverage to all Americans through health insurance market reform
- Consumer choice of plans to encourage competition that favors quality, affordability, and appropriate patient care
- Essential health insurance reforms that eliminate coverage denials based on pre-existing conditions
- Medicare reforms including repeal of the sustainable growth rate (SGR) formula
- Chronic disease management and care coordination through additional funding for primary care services, without imposing offsetting payment reductions on specialty care
- Addressing the growing physician workforce concerns
- Prevention, wellness and patient responsibility initiatives designed to keep Americans healthy
- Making needed improvements to the Physician Quality Reporting Initiative that will enable greater participation by physicians
- The private practice of medicine on a fee-for-service basis within a pluralistic system of health care delivery
- Medical liability reform (with the understanding that it will not adversely affect Indiana or other states effective tort reforms)
- Responsible physician investment in technology, facilities, services and equipment that results in high quality, efficient, effective health care
- Physicians' voluntary participation in any health plan
- Health reform that is meaningful, fair and sustainable
- Reducing oppressive and arbitrary administrative regulations set by insurers and government agencies that compromise patients' safety and health
- Health reform that includes improved responsiveness to physicians concerns from insurance companies and government agencies

(READOPTED 09-32, HOD; READOPTED 99, HOD; RESOLUTION 86-7) RESOLVED, that physicians of Indiana will not compromise the quality of medical care because of financial incentives.

(RESOLUTION 08-32) RESOLVED, that the ISMA review and support when appropriate health care regulation to advance legitimate patient care, patient safety or quality issues and oppose regulation that does not.

(7/15/79, BOT) That the optimal patient-physician relationship is founded in freedom of choice and mutual responsibility--a relationship best achieved under a fee-for-service system for the delivery of medical services.

HEALTH FACILITY SAFETY AND SECURITY

(RESOLUTION 07-11) RESOLVED, that the ISMA work with the Indiana Hospital & Health Association and other interested organizations to promote workplace safety for physicians and other health care workers.

HEALTH PROFESSIONS BUREAU (PROFESSIONAL LICENSING AGENCY)/ LICENSING ISSUES

(RESOLUTION 16-46) RESOLVED, that there is a benefit to members of the ISMA in forming an ad hoc committee to review the option of removing MOC as a condition of licensure, reimbursement, employment or hospital privileging, and yet have a way to ensure continued education and advancement of our physicians.

(RESOLUTION 15-37) RESOLVED, that the ISMA oppose further requirements for physician board certification of Indiana physicians beyond the 10-year board re-certification exams, placing on hold any additional

Maintenance of Certification (MOC) requirements until objective study of the validity and cost-effectiveness of such additional requirements are complete.

(RESOLUTION 14-29) RESOLVED, that the ISMA ask the Indiana Attorney General to establish a policy of not investigating anonymous complaints against physicians when there is no other information suggesting a potential physician problem.

(READOPTED 14-18; RESOLUTION 04-26) RESOLVED, that the ISMA seek legislation requiring licensure fees health providers pay to the state of Indiana go directly to the budget of the Medical Licensing Board of Indiana, rather than the general fund of the state budget.

(READOPTED 13-45; RESOLUTION 03-38) RESOLVED, that the ISMA continue to recognize the benefits of placing a psychiatrist on the Medical Licensing Board or Indiana; and be it further
RESOLVED, that the ISMA encourage the Medical Licensing Board (MLB) of Indiana to collaborate with the president of the Indiana Psychiatric Association when appointing a psychiatrist as a member of the MLB.

(RESOLUTION 12-33) RESOLVED, that the ISMA formally request an accounting from the State of Indiana as to the total amount of monies generated from physician licenses, fees and fines, as well as the total amount expended by the Medical Licensing Board of Indiana for assuring the quality of medical care in Indiana; and be it further,
RESOLVED, that the ISMA pursue administrative or legislative remedies to allocate medical licensing fees first to the Medical Licensing Board of Indiana for its activities, to include investigators, education and re-entry program costs.

(READOPTED 11-14, AMENDED by HOD; RESOLUTION 01-20) RESOLVED, that the ISMA continue to offer the Attorney General's Office and other interested agencies volunteer physicians who can serve to render consultations to the agencies free of charge and in an expeditious manner.

(RESOLUTION 11-02) RESOLVED, that: (1) ISMA non-members who are participants of the ISMA Commission on Physician Assistance (COPA) program be assessed on a prorated basis a portion of the costs associated with and incurred by the COPA. This cost may be paid upon contracting or at such time as the impaired physician once again becomes a fully functional member of the medical community, to be determined by the Executive Committee, the Board of Trustees and COPA; and (2) that an exclusion from payment in the form of a hardship exception be incorporated into the policy and exercised at the discretion of the COPA.

(RESOLUTION 11-47) RESOLVED, that the ISMA support legislation regulating tattooing and body piercing via the Professional Licensing Agency, in a manner similar to other such professions.

(RESOLUTION 10-55) RESOLVED, that the ISMA seek, with the assistance of the Indiana Academy of Ophthalmology and the Indiana Society of Anesthesiology, to facilitate a discussion with the Medical Licensing Board of Indiana as to whether or not to retain or exclude from their rule regarding office based surgery retrobulbar and peribulbar anesthetic procedures when performed appropriately by board certified ophthalmologists.

(READOPTED 10-20, HOD; RESOLUTION 00-48) RESOLVED, that the ISMA seek support from the governor and the legislature to adequately fund and improve the operation of the Health Professions Bureau.

(READOPTED 09-34, HOD; READOPTED 99, HOD; RESOLUTION 87-16) RESOLVED, that the ISMA monitor the Professional Licensing Agency to ensure that effective methods are being used to promptly notify the appropriate entities of physician licensure restrictions.

(RESOLUTION 07-09) RESOLVED, that the ISMA vigorously request that the Indiana Health Professions Bureau remove all additional fees and surcharges attached to the cost of both the Indiana State Controlled

Substances License and Indiana State Medical License so as to keep their costs at or below (due to decreased overhead from online renewal) $60 and $200 respectively.

HEALTH SERVICES - LOCAL

(RESOLUTION 16-49) RESOLVED, that the ISMA Commission on Legislation work with the interested legislator to develop the appropriate language for a bill that will facilitate acute stroke care for Indiana residents.

(RESOLUTION 15-31) RESOLVED, that the ISMA ask the AMA to study health care for incarcerated individuals and to identify the best health care models for local, state and federal facilities. Once this study is complete, the ISMA Board of Trustees shall determine which health care options for incarcerated persons are most practical for Indiana jails and prisons; and be it further
RESOLVED, that the ISMA advocate for improved health care of incarcerated individuals to the public, governor, legislature, Indiana Department of Correction, Indiana Sheriff's Association and other vested parties and individuals.

(RESOLUTION 15-24) RESOLVED, that the ISMA educate Indiana House and Senate budget committees on the need to significantly increase the budget for public health services, as well as educate the governor and legislators on the need to increase public health funding by rule and statute; and be it further
RESOLVED, that the ISMA encourage state leaders to redouble their efforts to collect more federal dollars for public health funding.

(READOPTED 09-54, HOD; RESOLUTION 99-6) RESOLVED, that the ISMA request the Indiana General Assembly, in concurrence with the governor, to fund all mandates passed to local health departments in order to assure the public heath workforce is adequate to protect the health of Indiana's citizens; and be it further,
RESOLVED, that the ISMA ask the Indiana General Assembly that adequate funds to carry out present state health mandates be provided by state budgetary appropriation for county health departments.

HEALTHY LIFESTYLES

(READOPTED 15-12, HOD; RESOLUTION 05-08) RESOLVED, that the ISMA develop further efforts to educate and encourage healthy lifestyles.

(RESOLUTION 12-61) RESOLVED, that the ISMA encourage the restriction of raw milk sales in Indiana for the health of Hoosiers.

(RESOLUTION 12-04) RESOLVED, that the ISMA adopt policy that encourages physicians to require patients to improve their unhealthy lifestyles (quit smoking and/or improve uncontrolled diabetes) before prescribing Schedule II and III medications on a long-term basis.

(RESOLUTION 12-03) RESOLVED, that the ISMA adopt policy to encourage hospitals to stop selling all soft drinks and other high fructose corn syrup-containing beverages from cafeterias and vending machines.

(RESOLUTION 10-04) RESOLVED, that the ISMA ask the Indiana AMA delegation to take the issue of mandated labeling of genetically engineered ingredients to the AMA House of Delegates for study of the impact of this problem and further action.

(RESOLUTION 07-01) RESOLVED, that the ISMA support and seek legislation requiring all restaurants with 10 or more locations to provide information on key nutrients (calories, saturated plus trans fat, carbohydrates, and sodium per serving) at point of sale for standard menu items.

HEIMLICH MANEUVER

(4/9/80, EC) Supports the Heimlich Maneuver as an appropriate emergency procedure for choking victims.

HELMETS – BICYCLE/MOTORCYCLE

(READOPTED 09-31, HOD; READOPTED 99, HOD; RESOLUTION 85-17) RESOLVED, that the ISMA support legislation to require protective headgear to be worn by all drivers and passengers of motorcycles and motor scooters at all times.

(READOPTED 08-14, HOD; RESOLUTION 98-04) RESOLVED, that the ISMA support legislation calling for mandatory use of bicycle helmets for minors and consider it mandatory for adults.

HIV

See: ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

HMOs

(READOPTED 08-12, HOD; RESOLUTION 98-34) RESOLVED, that medical directors of insurance entities be held accountable and liable for medical decisions regarding contractually covered medical services; and be it further,
RESOLVED, that the ISMA undertake whatever legislative and regulatory measures necessary to bring about this accountability; and be it further,
RESOLVED, that the ISMA direct the Indiana delegation to the AMA to convey this resolution to the AMA for implementation into AMA policy and federal legislative agenda at the 1998 interim meeting of the AMA; and be it further,
RESOLVED, that the ISMA ask that insurance entities be required to explain to the covered members what is and what is not a contractually covered medical service.

(READOPTED 08-11, HOD; RESOLUTION 98-37) RESOLVED, that the ISMA seek legislation to place liability for medical malpractice on an HMO that makes a determination of medical necessity contrary to a recommendation of a patient's physician that falls within normal standards of medical practice and includes contractually covered medical services.

(7/15/79, BOT) The ISMA in its support of pluralistic health care delivery systems recognizes freestanding, prepaid capitation programs as one form of delivery of medical services. The presence of such programs in a community may provide a choice to the individual patient under certain circumstances. However, an objective evaluation of all forms of medical care delivery systems can only exist in an atmosphere free of artificial restraints on or advantages to any one delivery system. Therefore, the ISMA strongly objects to federal subsidization, either fiscally or legislatively, of any one form of delivery system as being inconsistent with an objective analysis and supports the concept of neutral public policy and free market competition.

HOME DELIVERIES

(READOPTED 09-33, HOD; READOPTED 99, HOD; RESOLUTION 86-36) RESOLVED, that the ISMA recommend enforcement of existing laws that prohibit midwifery by unlicensed individuals.

(READOPTED 09-28, HOD; READOPTED 99, HOD; RESOLUTION 81-27) RESOLVED, that the ISMA encourage the delivery of all pregnancies in a hospital or in those settings best suited to minimize the risk to the mother and infant.

HOSPITALS

(RESOLUTION 16-37) RESOLVED, that the ISMA adopt policy similar to that of the AMA, reaffirming the rights of employed physicians, that includes:

- Every employed physician has a right to be treated with dignity and respect.
- The physician-patient relationship is sacred and should be preserved when possible, even when physicians leave a practice, group or facility. That is, both parties should be allowed to continue the professional relationship.
- Employed physicians, when they quit or are terminated, are entitled to their patients' addresses, phone numbers and the content of their medical record.
- Employed physicians' patients have a right to access information about their prior physician including their physicians' new locations and phone numbers.
- Employed physicians should be afforded adequate training so as to maintain skills, knowledge and competency.
- Employed physicians should receive a salary commensurate with their work effort and professionalism.
- Employed physicians should receive reasonable vacations and time on call. Excessive on-call time reduces productivity and physician satisfaction and increases the risk of medical error.
- Employed physicians should not be penalized for time off for pregnancy and child care; and be it further

RESOLVED, that the ISMA adopt policies, in addition to AMA policies, stating that:

- Employed physicians should not be penalized for the diminished productivity and utility of electronic medical records (EMR) and server inefficiencies. Employers should strive to acquire an efficient and fully functional EMR and, when possible, provide a scribe to help improve physician efficiency.
- Employed physicians have a right to their medical practice financial data and to their peers' comparison data, including ancillary income generated by the employed physician, as well as referral physicians. It is important for employed physicians to know their contribution to the financial health of their organization and/or medical facility.
- Employed physicians should not be subjected to non-compete clauses or contracts.

(RESOLUTION 16-26) RESOLVED, that the ISMA formally engage in discussions, at any promising level, with Indiana hospitals regarding the impact on physicians of federally mandated payment programs (e.g. MACRA); and be it further
RESOLVED, that the ISMA share current clinical research regarding trends in physician depression, burnout and suicide with Indiana hospitals as it becomes available (the AMA Steps Forward Program, for example), along with examples of "best efforts" to change or improve any harmful factors; and be it further
RESOLVED, that the ISMA explore a means for a representative group (e.g. our Board of Trustees or Executive Committee) to formally interact with Indiana hospitals in any future organizational structure of the ISMA. This would occur on at least a yearly basis to discuss physician practice options to help maintain/retain sufficient physicians to provide appropriate patient care in Indiana (e.g. promoting use of scribes, voice recognition software, more skilled medical staff).This should include open discussions on the financial implications (costs) of such choices and their impact on physician retention.

(RESOLUTION 16-25) RESOLVED, that the ISMA Board of Trustees pursue a closer, more direct relationship with Indiana hospitals and/or the Indiana Hospital Association to promote attainment of mutual organizational goals; and be it further
RESOLVED, that the ISMA Board of Trustees form a temporary committee to study increasing ISMA membership among hospital-employed physicians; this committee should report back to the ISMA Board of Trustees and House of Delegates by 2017 or 2018.

(RESOLUTION 16-01) RESOLVED, that ISMA policy and legislative efforts support physician-owned hospitals.

(RESOLUTION 13-13) RESOLVED, that the ISMA, with other health and hospital groups, promote the importance of proper hand cleansing for all health care providers in order to reduce hospital-associated infections and deaths.

(RESOLUTION 12-16A) RESOLVED, that the ISMA support legislation that requires county hospitals to include physicians from their medical staffs on their hospital boards.

(RESOLUTION 11-41) RESOLVED, that the AMA will strive to become the lead association for employed physicians within the U.S.; and be it further,
RESOLVED, that the AMA will establish an employed physician division with such services as contract review, employee-employer relation services, mediation and other services deemed appropriate by the House of Delegates and the Board of Trustees; and be it further,
RESOLVED, that the AMA will establish an employed physician section with full voting and leadership rights as determined by the Bylaws and Constitution; and be it further,
RESOLVED, that the AMA modify its bylaws and constitution to require a certain minimum percentage of the AMA Board of Trustees consist of employed physicians; and be it further,
RESOLVED, that this resolution (11-41) will be sent to the AMA for discussion and consideration if adopted by the ISMA House of Delegates.

(READOPTED 10-47, HOD; RESOLUTION 00-15) RESOLVED, that the ISMA introduce legislation to amend Indiana Code 16-22-2-2 to mandate or require active medical staff physician representation on the respective county hospital governing boards; and be it further,
RESOLVED, that any and all active medical staff physician members of county hospital governing boards not be contracted employees of their respective county hospitals, its governing board, or any of its public or privately developed corporations.

(READOPTED 09-30, HOD; READOPTED 99, HOD; RESOLUTION 84-24) RESOLVED, that the ISMA oppose efforts by any hospital that serves to limit physicians' free choice and competitive alternatives through the closing of medical staffs, sections of medical staffs, or which limit physician access to services based on arbitrary objectives that do not clearly enhance patient care.

(2/15/95, EC) Approved the following policy relating to anti-trust laws covering hospitals:

- The state of Indiana should only grant two waivers (exempting certain hospitals from anti-trust laws).
- The state cannot provide an exemption unless they get a resolution from the medical staffs stating support for the merger.
- The EC would support future ISMA efforts to get state action exempted if such is deemed necessary by the ISMA. This support should be written to the ISMA Board of Trustees.

IMMUNIZATIONS

(RESOLUTION 15-43) RESOLVED, that the ISMA support education and appropriate use of the Human Papillomavirus vaccines in both male and female individuals.

(READOPTED 15-16, HOD; RESOLUTION 05-23) RESOLVED, that ISMA staff work with the appropriate Indiana State Department of Health staff and the suppliers of vaccines to develop a plan for the distribution of vaccines in case another disaster occurs regarding availability, so that physicians will be involved in the provision of care to their patients.

(RESOLUTION 11-37) RESOLVED, that the ISMA support legislation requiring employed child care providers and health care workers of children less than 12 months of age to be vaccinated against pertussis, absent an objection on religious grounds or a determination by a physician that the vaccination would be detrimental to the person's health; and be it further,
RESOLVED, that the ISMA support vaccination status of a facility's child care providers and health care workers be available upon request; and be it further,
RESOLVED, that the ISMA support pertussis vaccination for all child care providers and family members.

(READOPTED 11-18, HOD; RESOLUTION 01-32) RESOLVED, that the ISMA use every means at its disposal to assure that all third-party payers reimburse for vaccinations recommended by the CDC; and be it further,
RESOLVED, that the ISMA identify third-party payers that fail to fully reimburse the cost of vaccinating patients; and be it further,
RESOLVED, that the ISMA use every means at its disposal to assure that physicians are properly reimbursed for the cost of procuring and the cost of administering vaccinations; and be it further,
RESOLVED, that the ISMA use every means at its disposal to assure additional reimbursement for evaluations or treatments given on the same day as the vaccinations are administered.

(RESOLUTION 11-10) RESOLVED, that the ISMA petition the state to reinstitute vaccination policies covering all children and adequately fund any programs; and be it further,
RESOLVED, that the ISMA work with the state to develop methods by which insurance companies are encouraged to assist in appropriate funding of the immunization program.

(READOPTED 10-61, HOD; RESOLUTION 00-24) RESOLVED, that the ISMA support efforts, legislative, administrative and educational, that seek to ensure Indiana children receive all CDC-recommended vaccinations.

(RESOLUTION 07-35) RESOLVED, that should dialogue with payers not result in adequate change in the reimbursement rate to cover the total cost of vaccination (vaccines, overhead and administration costs), that the ISMA work with the appropriate entities to seek and support legislation that will provide adequate reimbursement.

INFANTS

(RESOLUTION 17-34) RESOLVED, that the ISMA seek and/or support legislation to expand the collection of all applicable data related to the identification and treatment of infants at risk for Neonatal Abstinence Syndrome (NAS) from all Indiana hospitals where such patients have been identified, with the information to be collected and submitted to the Indiana State Department of Health.

(RESOLUTION 15-45) RESOLVED, that the ISMA actively support efforts of the Indiana State Department of Health, the Indiana chapters of ACOG, AAP, AAFP and others to reduce preventable premature births in Indiana through the promotion of:

- Screening of all pregnant women for risk of premature delivery by obtaining:
    - A history of a prior premature delivery, and
    - Cervical length measurement for pregnant women at risk, and
- Timely use of progesterone in all appropriate pregnant women; and be it further

RESOLVED, that the ISMA support all efforts to reduce financial and administrative barriers to the appropriate use of progesterone in pregnant women.

(RESOLUTION 14-14 BOT) RESOLVED, that the ISMA endorse the addition of SCID (Severe Combine Immune Deficiency) to existing Indiana newborn screening, and support legislative efforts to fund this new preventative strategy.

INSPECT

(RESOLUTION 14-02) RESOLVED, that the ISMA support legislation that would permit Indiana licensed residents and fellows to use the Indiana Scheduled Prescription Electronic Collection and Tracking (INSPECT) program, for instance, by registering with an NPI or through the creation of an institutional INSPECT account.

(RESOLUTION 12-48) RESOLVED, that the ISMA seek and support legislation that will adequately fund INSPECT.

INSURANCE – CODING

(READOPTED 12-51; RESOLUTION 02-24) RESOLVED, that the ISMA continue to confront unilateral code-collapsing and recoding practices by insurers; and be it further,
RESOLVED, that the ISMA request that Anthem no longer require physicians to sign a contract that permits Anthem to reassign and rebundle CPT codes.

(RESOLUTION 11-39) RESOLVED, that the AMA work to establish a unique billing code (G code) for completion of the Face-to-Face Encounter form and reimbursement for the code; and be it further
RESOLVED, that the AMA investigate the possibility of incorporating the questions required for the Face-to-Face Encounter into a new modified form 485 for the sake of simplicity and efficiency. This new modified form should also have a higher level of reimbursement than the current Form 485; and be it further,
RESOLVED, that if this resolution (11-39) is approved by the ISMA House of Delegates, it will be sent to the AMA for discussion and consideration.

(RESOLUTION 10-54; AMENDED EXISTING POLICY 00-59) RESOLVED, that the ISMA support the correct use of AMA CPT guidelines for coding and payment by payers.

(READOPTED 09-40, HOD; READOPTED 99, HOD; RESOLUTION 89-4) RESOLVED, that the ISMA and the AMA combat severe sanctions and harsh and unreasonable penalties that are leveled against physicians because of errors in the coding process.

(RESOLUTION 08-17A) RESOLVED, that the ISMA direct the AMA Delegation from Indiana to present a resolution at the AMA requesting a new CPT code be created to describe the time and resources needed by physicians for concurrent care and coordination of care of patients in the hospital and seek reimbursement for the same.

INSURANCE – CONTRACTS

(READOPTED 14-20; RESOLUTION 04-28) RESOLVED, that the ISMA support legislation that would permit language be added to managed care health plan contracts allowing providers to apply billed charges, without discount, to those patients who do not pay the required balances within 60 days of claim adjudication.

(RESOLUTION 13-44) RESOLVED, that the ISMA work with the Indiana state legislature to produce regulations prohibiting the use of “all products” clauses in provider contracts; and be it further
RESOLVED, that the ISMA work with the state legislature to ensure that the “exchange” plans are considered new products.

(RESOLUTION 08-34A) RESOLVED, that the ISMA direct the AMA Delegation from Indiana to request that the AMA support any change in the anti-trust legislation laws to allow groups of physicians the ability to negotiate

with insurance payers when the carrier has a private market penetration of 60 percent or greater in a given community.

(RESOLUTION 08-29) RESOLVED, that the ISMA shall pursue enactment of legislation supporting the right of physicians to operate their practices using sound business principles and banning "Open Access" language in commercial insurance contracts.

INSURANCE – COVERAGE

(Resolutions 17-25) RESOLVED, that consistent with AMA Policy H-185.931 *Coverage for Chronic Pain Management*, ISMA advocate for an increased focus on comprehensive, multidisciplinary pain management approaches that include the ability to assess co-occurring mental health or substance use conditions, are physician-led, and recognize the interdependency of treatment methods in addressing chronic pain; and be it further
RESOLVED, that ISMA advocate for private and government-sponsored health plans that provide coverage that gives patients access to the full range of evidence-based chronic pain-management modalities, and that coverage for these services be equivalent to coverage provided for medical or surgical benefits; and be it further
RESOLVED, that ISMA support efforts to expand the capacity of practitioners and programs capable of providing physician-led interdisciplinary pain management services, which have the ability to address the physical, psychological, and medical aspects of the patient's condition and presentation and involve patients and their caregivers in the decision-making process; and be it further
RESOLVED, that ISMA seek legislation to require health insurers and government-sponsored plans to cover the full range of physician-led, evidence-based chronic pain management modalities at a level commensurate to other medical or surgical benefits.

(RESOLUTION 16-17) RESOLVED, that the ISMA support adoption of the AMA model legislation "Ensuring Transparency in Prior Authorization Act."

(RESOLUTION 15-39) RESOLVED, that the ISMA support and engage in state legislation that will improve step therapy protocols by ensuring they are safe for patients, clinically grounded and transparent to patients and health care providers. State legislation should: 1) ensure step therapy programs are based on clinical guidelines developed by independent clinical experts, 2) ensure the exceptions process for step therapy is transparent and accessible for patient and health care providers, and 3) establish a basic framework for when it is medically appropriate to exempt patients from step therapy.

(RESOLUTION 15-32) RESOLVED, that the ISMA support and engage in legislation requiring counties to provide adequate insurance for public health medical liability for county health officers that would cover the expanded scope of health officers' orders, policies and services where necessary.

(READOPTED 12-53, HOD; RESOLUTION 02-31) RESOLVED, that the ISMA use whatever means possible to encourage and/or require third-party payers to notify physicians and insurees of services or diagnoses that will not be covered by their plans prior to membership or participation in said plans; and be it further,
RESOLVED, that third-party payers be required to make available to physicians and insurees a list of all services that will not be covered by their plans. This list should be available prior to membership or participation in said plans. Physicians and insurees should be notified immediately of any changes; and be it further,
RESOLVED, that physicians shall not be prohibited from collecting from patients for non-covered services.

(RESOLUTION 11-15) RESOLVED, that the ISMA support a patient's right to a determination of medical necessity and payment approval for elective procedures (such as reduction mammoplasty) with properly submitted medical evidence prior to the procedure and, if denied, have the reason for denial and the right to due process.

(READOPTED 10-56, HOD; RESOLUTION 00-22) RESOLVED, that the ISMA support efforts by the Indiana Legislative Commission on Autism, the Indiana Resource Center for Autism and other appropriate agencies in their efforts to legislate health care insurance for autistic children; and be it further,
RESOLVED, that the ISMA encourage and support appropriate state agencies, advocates and legislators in their efforts to extend legislated health care insurance coverage for treatment of children with autism spectrum disorders to all state and federally regulated health insurance programs.

(RESOLUTION 10-16) RESOLVED, that the ISMA support state legislation requiring:

- An employer to have a 30-day time limit to notify an insurance company/network that an employee is no longer eligible under their medical plan
- A health plan to enter the non-eligibility of the employee within 10 days of notification from the employer, enabling the provider to verify coverage before services are rendered

(RESOLUTION 10-15) RESOLVED, that if a reasonable pattern of requesting and obtaining prior authorizations can be confirmed, the ISMA seek and/or support any and all efforts, including legislative efforts if necessary, to mandate that care provided in good faith by physicians or other providers CANNOT be denied SOLELY on the basis of failure to have an authorization. Full consideration of medical necessity and appropriateness of services provided MUST be factored into any denial decision; and be it further,
RESOLVED, that this resolution be carried forward by our delegation to the AMA.

(RESOLUTION 09-04) RESOLVED, that the ISMA support legislation that upon denial of coverage for prescribed medications requiring prior authorization, insuring entities shall provide a list of alternative FDA-approved medications appropriate to the diagnosis**.**

(RESOLUTION 08-28) RESOLVED, that the ISMA support legislation requiring physician assistants to carry their own malpractice insurance policies.

(RESOLUTION 07-34) RESOLVED, that the ISMA support passage of legislation by the Indiana General Assembly that would provide all citizens with health insurance coverage, improve affordability, ensure patients' choice of medical providers, and focus on disease prevention and health promotion; and be it further,
RESOLVED, that any such legislation to provide all citizens with health insurance coverage also achieve reduction in health insurance administrative costs by requiring uniform administrative processes including, but not limited to, claim submission, procedure authorization, prescription drug access and claim payment.

(11/19/78, BOT) Reaffirmed the necessity of working for the development of a catastrophic insurance program in the private sector that would be available to all citizens of the state of Indiana and to take the lead in publicizing this program and assuring coverage.

INSURANCE - CREDENTIALING

(RESOLUTION 08-42A) RESOLVED, that the ISMA educate the membership in regard to CAQH credentialing opportunities, the law requiring insurance carriers to use the CAQH credentialing services and option of reporting of non-complying insurance carriers to the Indiana Department of Insurance.

INSURANCE - PATIENT/PHYSICIAN PROTECTIONS

(RESOLUTION 17-30) RESOLVED, that ISMA support medical competency at health-plan medical-director levels by defining and creating policy that coverage decisions are indeed the practice of medicine and, therefore, subject to all laws and regulations attached to that designation; and be it further
RESOLVED, ISMA seek legislation that requires health-plan medical directors to be physicians with a broad knowledge of medical services, or a physician of the same specialty as the requesting physician (when feasible) to make care determinations impacting patients and practicing physicians.

(READOPTED 12-55, HOD; RESOLUTION 02-39) RESOLVED, that the ISMA pursue all avenues to achieve Anthem's fair play in the marketplace, which may include, at the appropriate time, a lawsuit against Anthem on behalf of our patients and the 8,000 ISMA member physicians in the state of Indiana.

(RESOLUTION 10-53; AMENDED EXISTING POLICY 00-52) RESOLVED, that the ISMA support the use of the standardized health identification card as developed by the Workgroup for Electronic Data Interchange (WEDI).

(READOPTED 09-37, HOD; READOPTED 99, HOD; RESOLUTION 88-28) RESOLVED, that it is the duty of any provider of medical insurance in the state of Indiana to fully inform in clear language prospective purchasers of insurance limitations, which may affect the quality or quantity of medical services provided under the plan. Examples of such features are:

1. Contracts or agreements between the insurers and physicians, hospitals, pharmacies or other providers of services which limit or affect care provided to the patient either directly or indirectly by limiting reimbursement in any fashion
2. Financial incentives, withholds, "gatekeeper" arrangements or other arrangements that may affect the medical decision-making process
3. Agreements that limit free referral of patients by the patient's physician to any other physician or hospital

(RESOLUTION 09-14) RESOLVED, that the ISMA seek legislation at the state level requiring health insurers to end the practice of rescission; and be it further,
RESOLVED, that the ISMA Delegation to the AMA introduce a resolution at the AMA 2010 House of Delegates meeting requiring health insurers to end the practice of rescission.

(RESOLUTION 09-10) RESOLVED, that the ISMA seek legislation in the 2010 Indiana legislative session requiring the Indiana Department of Insurance to receive all physician and other provider complaints against health insurance companies, regardless of the dollar amount, through electronic means.

INSURANCE – REIMBURSEMENT

(RESOLUTION 17-31) RESOLVED, that ISMA promote the appropriate use of prior authorization primarily for initial requests and services that fall outside the standard of care; and be it further
RESOLVED, that ISMA implement and promote policy that minimizes the need for prior authorization annually or on any other schedule when the request is for continuity of care and the prior authorization is for regimens that are working well to control a patient's condition; and be it further

RESOLVED, the ISMA create a policy that prior authorizations need to be completed within three working days by the health plan or pharmacy if approved, or if the prior authorization is denied, the denial must include an explanation, unique and specific to the individual patient, and, if no answer is obtained within three days, the prior authorization is deemed approved and patient care may proceed; and be it further
RESOLVED, that ISMA create a policy for the prior authorization process that, unless a health plan, pharmacy vendor or other payer source can document that medical care or a specific service or pharmaceutical is NOT appropriate or medically-indicated based on nationally recognized evidence-based guidelines, the health plan, pharmacy vendor or other payer source shall approve the request of the attending physician; and be it further
RESOLVED, that ISMA schedule quarterly meetings with insurance companies to discuss any prior authorization issues, as well as any other matters pertinent to physicians and patients; and be it further
RESOLVED, that ISMA support any effort to allow the physician to bill the insurance company directly for prior authorization time, and that the cost not be a pass-through charge to the patient; and be it further
RESOLVED, that the ISMA-AMA Delegation take this resolution to the AMA meeting for consideration and advocacy action both by administrative and/or legislative means; and be it further

RESOLVED, that the ISMA and the AMA work to address the problem of excessive burden from prior authorizations and meaningful use regulations by regulatory and/or legislative means; and be it further
RESOLVED, that the AMA delegation from the ISMA take the information to the AMA that Medicare Advantage plans follow Medicare guidelines if the plan chooses to follow their own guidelines. The plan must be transparent on the criteria for approval or denial.
(RESOLUTION 15-27) RESOLVED, that the ISMA support state legislation requiring insurance companies to reimburse providers for services provided during the ACA insured's grace period; and be it further
RESOLVED, that our AMA delegation take Resolution 15-27 to the AMA for consideration if they do not have this policy currently or if federal law changes are necessary to eliminate the abuse.

(RESOLUTION 15-23) RESOLVED, that the ISMA seek administrative rule or legislation that would require fair reimbursement for vaccines and administration for all health care providers in Indiana. This administrative rule or legislation would:

- Address the inadequate and timely reimbursement relative to the purchase price of vaccines as reflected on the updated CDC vaccine price website at: www.cdc.gov/vaccines/programs/vfc/cdc-vac-price-list.htm.
- Mandate health plans and insurance company payment to private sector physicians and all mid-level providers of current ASP (Average Sales Price), PLUS adjusted quarterly and retro back to date of price change.
- Mandate vaccine payments to the above providers for vaccine administration at a standardized rate (cost PLUS).

(RESOLUTION 15-22) RESOLVED, that ISMA seek legislation to allow a medical practice to opt in or out, in writing, on the use of virtual credit cards before insurers can use them; and be it further
RESOLVED, that legislation sought by the ISMA include a provision that insurers cannot penalize a medical practice for opting out of accepting virtual credits cards as payment.

(READOPTED 15-18, HOD; RESOLUTION 05-05) RESOLVED, that the ISMA House of Delegates encourage the Indiana General Assembly to assist the physicians of Indiana by enacting assignment of benefits legislation.

(READOPTED 15-15, HOD; RESOLUTION 05-56) RESOLVED, that the ISMA work with the Indiana Academy of Family Physicians to enact state legislation making complete payer fee schedules and reimbursement practices readily available.

(READOPTED 14-43; RESOLUTION 04-01) RESOLVED, that the ISMA ask the Indiana General Assembly to prohibit insurance companies and third-party payers from offsetting payments from one patient's account to another, and from offsetting payments from a gross amount to recoup payments made to patients; and be it further,
RESOLVED, that the ISMA ask the Indiana General Assembly to prohibit insurance companies and third-party payers from adjusting claims that are older than the allowed limit for filing claims. (To wit: If physicians have a 90-day limit to file claims, insurance companies have a 90-day limit to make adjustments.)

(RESOLUTION 13-14) RESOLVED, that the ISMA delegation to the AMA present a resolution to the AMA that seeks federal legislation requiring full insurance coverage for ALL eating disorders, including inpatient and outpatient care, as well as maintenance care.

(READOPTED 12-54, HOD; RESOLUTION 02-33) RESOLVED, that the ISMA seek and support legislation that would prevent health insurance companies, health maintenance organizations and third-party administrators (payers) from denying reimbursement for services that are covered services eligible for reimbursement under the patient's health benefit plan solely on the basis that administrative rules of the payer were not followed.

(READOPTED 12-52, HOD; RESOLUTION 02-26) RESOLVED, that the ISMA acts to make it mandatory for all insurance companies to send payments to the physician once the patient assigns benefits, whether or not the doctor is a preferred provider in the insurance plan.

(RESOLUTION 12-29) RESOLVED, that the ISMA seek legislation requiring that all health insurance companies, HMOs and health plans provide physicians, as part of their proposed and final network agreements, all relevant fee schedules; and be it further,
RESOLVED, that the ISMA seek legislation requiring that all health insurance companies, HMOs and health plans make their entire fee schedules accessible upon formal written request to all providers in an electronic usable format.

(RESOLUTION 12-22) RESOLVED, that the ISMA seek legislative and/or regulatory reform that requires equal enforcement of the "Indiana Prompt Pay Act," closing the loopholes that allow ERISA plans and companies that are self-insured to escape enforcement to the financial detriment of health care providers.

(RESOLUTION 10-59) RESOLVED, that the ISMA support policy that assures that public health care monies be used for providing patient health care; and be it further,
RESOLVED, that if insurance companies receive funding from the government or through governmentally mandated programs, then such funding shall have attached stipulations that require the following:

- All officer salaries shall be no more than the salary of the president of the United States.
- Board member salaries shall be limited to the daily rate for U.S. senators.
- Reimbursement for travel shall be no greater than that amount allowed for government employees.
- Corporate yearly dividends shall be limited to no more than the one-year T-bill rate.

(READOPTED 10-52, HOD; RESOLUTION 00-40) RESOLVED, that the ISMA work with the legislature to support laws for payment of services rendered with penalties to insurance companies for improper denials, including but not restricted to denials based on multiple physician visits on the same day.

(RESOLUTION 10-42) RESOLVED, that the ISMA formally take measures to have the insurance industry reimburse physicians for services rendered, as it relates to excessive time spent obtaining prior authorizations.

(READOPTED 09-35, HOD; READOPTED 99, HOD; RESOLUTION 87-20) RESOLVED, that the ISMA seek imposition of federal and/or state sanctions on the insurance carriers that do not reimburse patients promptly or correctly.

(READOPTED 09-29, HOD; READOPTED 99, HOD; RESOLUTION 82-6) Rescinded RESOLUTION 62-26 (adopted at a special meeting of the ISMA House of Delegates); and be it further,
RESOLVED, that the ISMA continue to oppose any third-party payment program that delineates physicians by lists or assignment or payments, or treats policyholders without uniformity.

(RESOLUTION 09-26) RESOLVED, that the ISMA work with the state Insurance Commissioner and/or the state legislature to encourage both private and public insurers to rebuild the prior authorization process with unified and simplified forms and processes, as well as an efficient and timely process for physicians to pursue appropriate exceptions for individual patients.

(RESOLUTION 08-45) RESOLVED, that the ISMA seek regulation or statute that defines pre-certification of medical services and prior authorization of pharmacy services as mandated services; and be it further,
RESOLVED, that the ISMA invoke by regulation or statute that insurance plans recognize and pay for claims documenting, with appropriate codes, and pre-certification of medical services and prior authorization of pharmacy services; and be it further,
RESOLVED, that the ISMA seek regulation or statute indicating that all plans providing administrative services or insurance products in Indiana are mandated by regulation or statute to pay for billed codes relating to

mandated care coordination services at the level defined by the Resource Based Relative Value Scale (RBRVS); and be it further,
RESOLVED, that the ISMA seek regulation or legislation that would force insurance plans acting as administrative services only (ASO) or fully insured plans to honor and pay for, on a Resource Based Relative Value Scale (RBRVS) basis, the CPT codes as promulgated by the AMA, and be it further,
RESOLVED, that this resolution be forwarded onto the AMA.

INSURANCE – TERMINOLOGY

(READOPTED 09-44, HOD; READOPTED 99, HOD; RESOLUTION 89-53) RESOLVED, that all remedies be taken by the ISMA to force the Centers for Medicare & Medicaid Services (CMS) and others to use "unreasonable and unnecessary" only for services and treatments that are considered unreasonable and unnecessary by the medical community; and be it further,
RESOLVED, that all remedies be taken by the ISMA to force CMS and others to not use "unreasonable and unnecessary" for services that they have simply decided not to accept as covered services.

(READOPTED 09-36, HOD; READOPTED 99, HOD; RESOLUTION 88-6A) RESOLVED, that the ISMA object to statements by insurers of appropriateness of care; that the ISMA urge all such statements by insurers and their designees be clearly limited to statements pertaining to whether the care or service is covered or not covered; and be it further,
RESOLVED, that the ISMA investigate whether attempts to determine appropriateness of care by third parties constitutes the practice of medicine without a license.

INTERNET MEDICINE

(RESOLUTION 13-27) RESOLVED, that the ISMA pursue legislation to prohibit dispensing of hearing aids online, which occurs without the proper medical evaluation, counseling, fitting, modification, follow-up care, repair services and support of an audiologist.

(RESOLUTION 11-26) RESOLVED, that the ISMA continue to work with the Medical Licensing Board of Indiana to assure guidelines for electronic physician/patient interactions are compatible with the evolution of electronic health records and preserve the physician/patient relationship with an emphasis on patient safety and access to care; and be it further,
RESOLVED, that the ISMA pursue discussion with third-party payers for recognition and reimbursement for electronic medical patient encounters; and be it further,
RESOLVED, that the ISMA provide education to members regarding the use of the Internet in medical practice; and be it further,
RESOLVED, that the ISMA pursue discussion with third-party payers for recognition and reimbursement for electronic medical patient encounters.

LABORATORY TESTS

(READOPTED 09-27, HOD; READOPTED 99, HOD; RESOLUTION 81-24) RESOLVED, that the pathologists, laboratories and practicing physicians in this state endeavor, wherever at all possible, to refer laboratory testing to qualified local, regional and state laboratories, so that the functional integrity of these necessary facilities may be maintained; and be it further,
RESOLVED, that the medical laboratories and pathologists in Indiana identify the needs of the physicians and patients in Indiana and endeavor to fulfill these needs.

LASER SURGERY

(READOPTED 10-22, BOT through referral from HOD for action; RESOLUTION 00-02) RESOLVED, that the ISMA adopt the policy that laser surgery should be performed only by individuals currently licensed by statute (MD or DO) and properly trained to practice medicine and perform surgical services.

MEDICAID

(RESOLUTION 17-05) RESOLVED, that the ISMA delegation to the AMA encourage the AMA to adopt policy that exempts self-employed small practices, defined as solo practitioners up to five physician providers, from the burdensome regulation of the merit-based incentive payment system (MIPS).

(RESOLUTION 17-02) RESOLVED, that ISMA petition the secretary of the Indiana Family and Social Services Administration and the commissioner of the Indiana Department of Insurance to require Medicaid and insurance companies to provide and compensate providers' offices for one nurse-education visit in the early second trimester of pregnancy and one nurse-education visit in the early third trimester of pregnancy to discuss signs and symptoms of preterm labor, preterm premature rupture of membranes, incompetent cervix and the dangers to an infant of low or very low birth weight. Reimbursement would be in addition to the global prenatal care reimbursement.

(RESOLUTION 16-41) RESOLVED, that the ISMA seek state legislation creating a mechanism to allow Medicaid patients to use Direct Primary Care (DPC) practices; and be it further

RESOLVED, that the ISMA seek state legislation defining DPC to be outside the scope of state insurance regulation; and be it further

RESOLVED, that the ISMA work with the AMA to seek federal changes to Internal Revenue Code 213(d) and 223(c) allowing health savings accounts to be used with Direct Primary Care, and allowing payments to DPC physicians to be considered a "qualified medical expense."

(RESOLUTION 16-09) RESOLVED, that the ISMA encourage the AMA to support an exemption from MIPS and MACRA for small practices since these rules will hasten the demise of small private practice in the U.S.

(RESOLUTION 15-38) RESOLVED, the ISMA advocate that the Office of Medicaid Policy and Planning pay for the medication-assisted treatment of nicotine-use disorders beyond three months in a 12-month period.

(READOPTED 12-56, HOD; RESOLUTION 02-42) RESOLVED, that the ISMA seek through any means available to have the Office of Medicaid Policy and Planning rescind the revised crossover claims methodology to more appropriately reimburse physicians for services provided.

(RESOLUTION 11-57) RESOLVED, that the ISMA support that any leveraged money gained by the hospital fee agreement to leverage federal payments be kept within the Medicaid program(s), and that those dollars be used to improve physician payment schedules.

(RESOLUTION 11-43) RESOLVED that the ISMA petition the Office of Medicaid Policy and Planning to: (1) make Medicaid spend-down collection regulations equal for physicians and pharmacies; and (2) modify the Medicaid spend-down collection regulations allowing physicians to collect Medicaid spend-down payments for out-of-pocket pharmacy expenses and services at the time these expenses are accrued and services are provided, removing inconvenience and delay of treatment for patients and giving more incentive for physicians to accept Medicaid patients.

(RESOLUTION 11-25) RESOLVED, that the ISMA petition the Office of Medicaid Policy and Planning, the state and the Indiana legislature (as needed) to adapt or modify the Right Choices Program in ways to avoid the

many intrusions into the physician/patient relationship that can result in prescribing medications without having seen or examined a patient, as well as disrupting the normal work flow of a physician office.

(READOPTED 11-20, HOD; RESOLUTION 01-38) RESOLVED the ISMA recognize and acknowledge that the Medicaid program faces serious funding problems in light of recent economic projections regarding the state budget; and be it further,
RESOLVED, that state legislation be initiated to assure state pharmaceutical rebate monies be returned to the Medicaid program and not the state's general fund; and be it further,
RESOLVED the ISMA, through its Board of Trustees and Commission on Legislation, immediately study efforts by other states to solve this problem in the Medicaid program and move forward in the next state legislative session with any means feasible in Indiana; and be it further,
RESOLVED, that if cost containment for medications in Medicaid requires the use of a Medicaid formulary, the ISMA actively seek participation in the construction of the formulary.

(RESOLUTION 10-17) RESOLVED, that ISMA policy is to increase Medicaid reimbursement to at least 100 percent of the greater of the Medicare reimbursement formula as of July 1, 2010, or the current level of reimbursement.

(READOPTED 09-62, HOD; RESOLUTION 99-56) RESOLVED, that the ISMA advocate for an adjustment of all Medicaid reimbursement rates in Indiana in order to bring Indiana's rates in line with Medicare rates in order to improve access to care for the growing number of Medicaid patients in our state.

(RESOLUTION 09-25) RESOLVED, that the ISMA through legislation, regulation or agreements work to stop the automatic assigning of managed care organization coverage for newborn infants in Indiana; and be it further,
RESOLVED, that the ISMA through legislation, regulation or agreements work to ensure that managed care organization coverage for newborn infants is retroactive to birth; and be it further,
RESOLVED, that the ISMA through legislation, regulation or agreements work to ensure managed care organization assignment is based upon the parent/family choice and/or the physician of record for services provided from birth, allowing appropriate contracted payment for services provided.

(RESOLUTION 08-20) RESOLVED, that the ISMA support legislation or administrative procedures to provide that Medicaid recipients enrolled in a Medicaid plan be required to remain in the same plan for one year, or the duration of their coverage if less than one year, so that patients have continuity of care through a medical home.

(READOPTED 08-15, HOD; RESOLUTION 98-23) RESOLVED, that the ISMA support legislation to provide Medicaid coverage for a period of nine months for all uninsured and poor patients with active tuberculosis.

(1/17/93, BOT) Approved the following report, as amended, from the ISMA Medicaid Reform Task Force:
A case management system should be implemented, including co-payments and deductibility of co-payments from other state support payments to the patient, if the patient fails to comply with co-payment requirements. Optional benefits should be reduced and a basic benefits package should be provided. The Health Professions Bureau (HPB) should be responsible for investigating fraud and abuse in the Medicaid program, and funding should be provided to the HPB to undertake these activities. The proposals here should be financed with an income tax increase, a sin tax on alcohol and cigarettes, eliminating the scheduled physician payment increase, and implementation of an RBRVS reimbursement schedule for Medicaid.

MEDICAL EDUCATION

(RESOLUTION 16-11) RESOLVED, that the ISMA support mandatory domestic violence curriculum in residency programs educating physicians to identify, screen and counsel patients who may be victims of such violence.

(RESOLUTION 16-05) RESOLVED, that the ISMA collaborate with all stakeholders in identifying opportunities for improvement in the education of Indiana practitioners in prescribing opioids.

(RESOLUTION 15-50) RESOLVED, that the ISMA explore developing a responsible prescribing program through continuing medical education focused on the responsible prescribing of controlled substances.

(RESOLUTION 15-08) RESOLVED, that our ISMA request the AMA develop a national campaign to educate the public on the definition and importance of Graduate Medical Education, student debt and the state of the medical profession today and in the future; and be it further
RESOLVED, that the ISMA continue to support and facilitate postgraduate medical education and CME in Indiana and help educate the Indiana public on the long-term economic and health benefits.

(RESOLUTION 11-45) RESOLVED, that the ISMA encourage Indiana physicians to continue to provide medical instruction without compensation; and be it further,
RESOLVED, that the ISMA recognize Indiana physicians' generosity and professionalism.

(RESOLUTION 11-19) RESOLVED, that the ISMA continue support for the regional medical campuses through continued personal participation, local legislative contact for adequate funding, and patient contact to improve community awareness of the need for adequate state funding to ensure high quality medical education and practitioners to care for Indiana citizens, now and into the future.

(RESOLUTION 10-44) RESOLVED, that the ISMA endorse the IU School of Medicine Dean's Council scholarship fundraising efforts and assist the school by informing the ISMA membership of opportunities for individual support and participation as a means for easing part of the student debt load facing our medical students.

(READOPTED 09-39, HOD; READOPTED 99, HOD; RESOLUTION 89-10) RESOLVED, that the ISMA, in cooperation with the IU School of Medicine and other organizations, develop and encourage the establishment of Medical Career Development Programs in high schools and universities throughout the state.

(READOPTED 09-38, HOD; READOPTED 99, HOD; RESOLUTION 89-13) RESOLVED, that the ISMA support the concept and help seek additional funding for Graduate Medical Education from the Indiana General Assembly.

(RESOLUTION 08-38) RESOLVED, that the ISMA work with the Indiana General Assembly to increase the amount of financial support directed to the IU School of Medicine with the new monies directed to reducing medical school tuition; and be it further,
RESOLVED, that the ISMA request a report from the IU School of Medicine regarding the long-term steps being undertaken to address the problem of increasing medical student debt and examine the sources and utilization of current funding; and be it further,
RESOLVED, that the ISMA request that the Indiana University Board of Trustees implement policies to increase the transparency of the tuition-setting process and consider a tuition freeze upon matriculation to Indiana University School of Medicine.

(RESOLUTION 08-01) RESOLVED, that the ISMA include on its yearly dues form an appropriate space for ISMA members to make donations to be applied to the IU Dean's Scholarship Fund; and be it further
RESOLVED, that the ISMA take a proactive stance and provide positive support for the IU School of Medicine Dean's Scholarship Fund.

(3/5/00, BOT) The ISMA opposes the establishment in Indiana of any medical education facility that seeks to provide instruction leading to a medical doctor (M.D.) or doctor of osteopathy (D.O.) degree if the facility is not accredited by the Liaison Committee on Medical Education (LCME) or the American Osteopathic Association (AOA).

(7/10/85, EC) Approved the Commission on Medical Education's recommendation to delegate provider responsibility to the ISMA Section on Directors of Medical Education/Association of Indiana Directors of Medical Education (AIDME). (The ISMA is the accrediting body for all intrastate institutions and organizations.)

(11/23/80, BOT) The ISMA supports federal grants for the IU School of Medicine and opposes any abrupt withdrawal of federal funds to medical schools.

(6/12/77, BOT) The ISMA will encourage CME on a voluntary basis and voice objection to CME being made a requirement for membership in the ISMA, as well as CME being made mandatory for relicensure and re-registration.

MEDICAL HOME

(RESOLUTION 07-13) RESOLVED, that the ISMA endorse the importance of the medical home for patients of all ages; and be it further,
RESOLVED, that the ISMA educate its members and the public about the medical home concept; and be it further,
RESOLVED, that the ISMA discuss with ancillary organizations representing nurse practitioners, physician assistants, pharmacists, etc., the importance of a medical home for patients, and be it further,
RESOLVED, that because retail clinics are completely contrary to the concept of medical home that the ISMA investigate and develop policy regarding these clinics, and be it further,
RESOLVED, that the fourth resolved only be referred to the ISMA Board of Trustees for action.

MEDICAL-LEGAL COMPACT OF CONDUCT OF THE ISBA AND ISMA

(READOPTED 09-41, HOD; READOPTED 99, HOD; RESOLUTION 86-6) RESOLVED, that the ISMA approve the Medical-Legal Compact of Conduct of the Indiana State Bar Association and the Indiana State Medical Association.

MEDICAL LIABILITY ISSUES

(READOPTED 09-63, HOD; READOPTED 99, HOD; RESOLUTION 86-32) RESOLVED, that the ISMA continue its efforts to ensure that the insurance commissioner does not allow arbitrary or capricious changes in malpractice premium or surcharge rates.

(READOPTED 09-61, HOD; RESOLUTION 99-52) RESOLVED, that the ISMA request the Indiana legislature be aware of the plight of those who work/volunteer at free clinics for indigent health care; and be it further,
RESOLVED, that the ISMA encourage the Indiana General Assembly to enact legislation that would provide professional employees of free clinics, as well as all volunteers, immunity from medical malpractice liability and be covered with a broad clinic malpractice insurance policy.

(RESOLUTION 09-23) RESOLVED, that the ISMA seek legislation that will provide physicians who are employees or contractors of the state or county immunity in all civil suits brought by inmates, including medical malpractice; and be it further,
RESOLVED, that the ISMA seek legislation requiring the Office of the Indiana Attorney General or appropriate authority to defend civil rights discrimination lawsuits brought against all physicians treating inmates of the state or county.

(RESOLUTION 09-08) RESOLVED, that the ISMA seek to encourage malpractice insurance companies to develop a plan of assistance for those physicians involved in a natural or personal disaster, such plan to apply for a period of one (1) to three (3) years from such event; such plan to include partial or complete remittance of premiums and continuation of policy coverage barring other unforeseen events.

(RESOLUTION 09-07) RESOLVED, that the ISMA recommend that the Medical Licensing Board of Indiana promulgate a rule that states the following:
Post-Surgical Care Responsibilities
After performing surgery, a physician shall continue care of their surgical patient through the post-surgical recovery and healing period either by providing the care directly, delegating the care to a person of equivalent licensure and appropriate training, or coordinating with another person of equivalent licensure and appropriate training who agrees to assume responsibility for managing the patient's post-surgical care. For purposes of this rule, "post-surgical recovery and healing period" shall be equivalent to the applicable Medicare postoperative global period for that surgical procedure.

(RESOLUTION 08-26) RESOLVED, that the ISMA seek to amend state law to extend physicians voluntarily donating care and time by providing services to patients referred to them by free clinics the same liability protection offered physicians who donate their time on-site at the clinic.

(RESOLUTION 08-22) RESOLVED, that the ISMA seek legislation or rules creating an exemption from licensing requirements for visiting medical personnel of sports teams similar to the statute in the state of California for physicians, with the addition of any other out-of-state licensed medical providers, such as physical therapists, athletic trainers, chiropractors, massage therapists, that accompany the visiting team; and be it further, RESOLVED, that the medical provider who is licensed to practice in another state or country shall be exempt from licensure requirements in this state while providing medical services to a sports team if all the following requirements are met:

1. The provider has a written or oral agreement with a sports team to provide care to the team members, coaching staff and families traveling with the team for a specific sporting event to take place in this state.
2. The provider may not provide care or consultation to any person residing in this state other than as listed in number 1 or under the Good Samaritan Act.
3. The exemption shall remain in force while the provider is traveling with the team, but shall be no longer than 10 days in duration per sporting event.
4. A maximum of 20 additional days per sporting event may be granted upon prior request by the provider to their respective licensing board but may not exceed 30 daye total per sporting event.
5. A provider who is exempt from licensure requirements under this provision is not authorized to practice at a health care clinic/facility including an acute care facility.
6. If the provider has been invited by the National Sport Governing Body to provide services at the national sporting training center or to provide services at an event/competition in this state sanctioned by the Body, then the provider meets the following requirements:
    a. The provider has been certified by the National Sport Governing Body in regard to state or country of origin licensure and the dates within which the provider has been invited to provide services.
    b. The provider's practice is limited to that required by the National Sport Governing Body. Those services shall be within the area of the provider's competence and shall only be provided to athletes or teams' personnel registered to train/coach at the center or registered to compete in an event sanctioned by the Body.
    c. The exemption shall remain in force while the holder is providing services at the invitation of the National Sport Governing Body and only during the time certified by the Body, but may not exceed 30 days total.

(8/2/92, BOT) Expressed the opinion that it is not unreasonable for a hospital medical staff to have, as a condition of medical staff privileges, that an Indiana physician is a "qualified health care provider" under Indiana's Medical Malpractice Act.

MEDICAL MARIJUANA

(RESOLUTION 16-18) RESOLVED, that the ISMA support a lesser DEA controlled substance schedule for cannabis, only to promote/facilitate research on the possible medical benefits of cannabis.

(RESOLUTION 14-22, Reaffirmed 11/22/15 BOT) RESOLVED, that the ISMA support research regarding the medical use of marijuana and its chemical components in controlled drug studies.

(RESOLUTION 12-28) RESOLVED, that the ISMA oppose any attempt by the legislature to pass a bill legalizing medical marijuana.

MEDICAL NUTRITION

(RESOLUTION 11-01) RESOLVED, that the ISMA seek coverage by Medicare, Medicaid and private insurers for dietary referrals to a registered dietitian by a physician for medical diagnoses that require a specialized diet; and be it further,
RESOLVED, that the ISMA recommend that the AMA delegation seek Medicare, Medicaid and private insurance reimbursement for dietary referrals to a registered dietitian by a physician for medical diagnoses that require a specialized diet.

MEDICAL RECORDS/INFORMATION

(RESOLUTION 16-27) RESOLVED, that the ISMA make available, on a trial basis, a list of resources to facilitate the completion of physician secretarial duties. This could include a list of current "best equipment" available for dictation, documentation and scheduling. It also could include an option for ISMA members to comment or add reviews (anonymously, as appropriate) of currently used equipment and software – whether selected by that physician or mandated by a group or hospital organization. The list could be reviewed annually.

(RESOLUTION 16-13) RESOLVED, that the ISMA ask the AMA to support federal legislation that will replace current meaningful use with common sense meaningful use developed by the medical profession that is user friendly and practical.

(RESOLUTION 13-38) RESOLVED, that the ISMA support legislation to absolve medical providers from the administrative burden of writing letters to patients who leave a practice voluntarily.

(RESOLUTION 11-56) RESOLVED, that the ISMA continue to pursue dialogue with the Indiana State Department of Health to reduce the burden of this online death registry process for physicians of Indiana; and be it further,
RESOLVED, that if agreed upon relief cannot be achieved by Indiana State Department of Health interaction, that the ISMA pursue other means, including legislative action if appropriate, to reduce the burden of the online death certificate registration system.

(RESOLUTION 11-38) RESOLVED, that the AMA work with the College of American Pathologists, the American Osteopathic College of Pathologists, the American Clinical Laboratory Association, the American Society for Clinical Laboratory Science, and other appropriate entities to produce a single standardized format for presentation of laboratory results. The standard should not only define where the test results and normal values will appear on the screen or the printed page, but also specify a consistent sequence for chemistry, hematology and other results; and be it further,

RESOLVED, that the AMA work with the American College of Radiology, the American Osteopathic College of Radiology and other appropriate entities to improve the terminology in both the descriptive and impression sections of a radiology report, as well as work towards producing a standardized format for the presentation of these radiologic results; and be it further,
RESOLVED, that the AMA shall encourage the federal government to set future standards for all electronic health/medical records allowing for an option to choose a standardized set of menus and medical information that has the same appearance regardless of vendor. However, the electronic health/medical record should also allow customization for the convenience of the user; and be it further,
RESOLVED, that this resolution (11-38), if approved by the House of Delegates of the ISMA, will be presented to the AMA for further consideration and adoption.

(RESOLUTION 10-69) RESOLVED, that the ISMA seek legislation to modify IC 16-37-1-3.1 to delay the start date of the Indiana electronic birth and death registries until Jan. 1, 2012, and modify IC 16-37-1-13 so that a person licensed under IC 25 (e.g., a physician) who is required to utilize the electronic registry but does not do so would be subject to possible disciplinary action by the appropriate licensing board rather than criminal charges; and be it further,
RESOLVED, that the ISMA continue to educate Indiana physicians regarding the electronic birth and death registries to increase awareness of their importance and efficiencies and to improve participation.

(RESOLUTION 08-18) RESOLVED, that ISMA ask the Indiana Health Informatics Corporation to encourage the development of bi-directional interfaces for order entry and for receiving finished data by both hospitals and physician offices, in order to standardize and allow systems from many different electronic medical record vendors to communicate with each other.

(RESOLUTION 07-16) RESOLVED, that the ISMA educate its members about the various EHR products that are compatible with hospital systems and state information systems; and be it further,
RESOLVED, that the ISMA educate its members about alternative SECURE means of communication when EHR is not available; and be it further,
RESOLVED, that the ISMA continue to monitor the effectiveness of various EHR products and publish its findings for members.

MEDICAL STAFFS

(READOPTED 13-15; RESOLTION 03-26) RESOLVED, that the ISMA continue to assist Indiana physicians in maintaining medical staff independence per accrediting agencies' standards for medical staff by-laws; and be it further
RESOLVED, that our ISMA continue to educate Indiana physicians as to the process for reporting violations to appropriate agencies, as well as direct physicians to resources to deal with medical staff bylaws issues; and be it further
RESOLVED, that our ISMA utilize the Ad-Hoc Committee on Hospital Medical Staff Organizations as needs arise; and be it further
RESOLVED, that our ISMA delegation to the AMA support efforts to keep medical staffs autonomous and independent.

MEDICAL STUDENTS

(RESOLUTION 17-29) RESOLVED, that ISMA collect data from various medical schools in Indiana regarding demographics of acceptance into medical schools, graduation, specialty, residency and practice location.

(RESOLUTION 17-17) RESOLVED, that ISMA allocate annual funding in the sum of $6,000 in support of the Health Policy Fellowship, $3,000 for a student from the Indiana University School of Medicine and $3,000 for a student from the Marian University College of Osteopathic Medicine, to sustain the program in future years and keep it competitive among other opportunities students might explore; and be it further

RESOLVED, that the ISMA Board of Trustees re-evaluate the Health Policy Fellowship every five years to keep the program competitive.

(RESOLUTION 15-34) RESOLVED, that the ISMA support the provision of on-campus mental health care in Indiana medical schools and residency programs that goes beyond supportive counseling; and be it further
RESOLVED, that the ISMA encourage ongoing and future initiatives by Indiana medical schools and residency programs to provide urgent and emergent access for all medical trainees to psychiatrists that could include an in-house board-certified psychiatrist; and be it further
RESOLVED, that the ISMA forward this resolution to our AMA for interim 2015 to encourage similar support for all medical students and residents across the country.

(RESOLUTION 14-37) RESOLVED, the ISMA shall encourage medical schools tangible to recognize and support medical student community and association involvement; and be it further
RESOLVED, that the ISMA shall encourage use of recommendation system to recognize medical student community and association involvement.

(RESOLUTION 13-18) RESOLVED, that the ISMA study the risks, benefits, costs, accreditation requirements and potential interest in a public/private partnership between the state and its hospitals, and insurance companies and private practices to expand graduate medical education in Indiana.

(RESOLUTION 12-42) RESOLVED, that the ISMA support the efforts of IU School of Medicine students and the Medical Student Section to address the needs of uninsured patients at the IU Student Outreach Clinic; and be it further
RESOLVED, that the ISMA encourage its members to donate their time and clinical experience to help ensure the continued success of the IU Student Outreach Clinic.

MEDICARE

(RESOLUTION 17-03) RESOLVED, that ISMA encourage the AMA to actively work to remove the sequester provision for Part B Medicare reimbursement.

(RESOLUTION 16-51) RESOLVED, that the ISMA work with the AMA to make seamless conversion enrollment into a Medicare Advantage Plan an opt-in rather than an opt-out process.

(RESOLUTION 10-13) RESOLVED, that the ISMA, working with its AMA delegation, seek to change the current Medicare policy about coverage for pharmaceuticals during the 23-hour observation stay, either by legislative means or administrative means; and be it further,
RESOLVED, that the ISMA, working with its AMA delegation, seek to change Medicare policy, either legislatively or administratively, to pay for medications needed by Medicare patients when they are admitted for 23-hour observation stays in hospitals.

(RESOLUTION 10-12) RESOLVED, that the ISMA set up a task force to study the mechanism of how to create an accountable care organization; and be it further,
RESOLVED, that the ISMA set up a task force to study the impact of bundled payments on physician practices; and be it further,
RESOLVED, that the ISMA, working with its AMA delegation, set up a task force at the AMA level to study bundled payments and accountable care organizations.

(READOPTED 09-42, HOD; READOPTED 99, HOD; RESOLUTION 89-50) RESOLVED, that the ISMA oppose cuts by Congress to Medicare appropriations.

(RESOLUTION 09-02) RESOLVED, that the ISMA encourage Medicare to cover expenses for dietary referrals for the diagnosis of obesity; and be it further,
RESOLVED, that the ISMA encourage the AMA delegation to seek Medicare reimbursement for dietary referrals for a diagnosis of obesity.

MENTAL HEALTH

(RESOLUTION 14-44) RESOLVED, that the ISMA advocate for improving access to psychiatric services by improving reimbursement; and be it further
RESOLVED, that the reimbursement for psychiatric services for Medicaid patients be increased to Medicare levels; and be it further
RESOLVED, that the ISMA advocate for the addition of psychiatry to family practice, internal medicine, pediatrics and obstetrics and gynecology as those specialties require additional reimbursement for Medicaid patients to Medicare levels; and be it further
RESOLVED, that this increased reimbursement for Medicaid patients to Medicare levels be continued beyond the two years as stipulated in the Affordable Care Act; and be it further
RESOLVED, that the ISMA Government Relations staff work with the AMA and all other stakeholders and members of Indiana's Congressional delegation to accomplish this goal through legislative means.

(READOPTED AND AMENDED 12-27, HOD; RESOLUTION 02-27) RESOLVED, that the ISMA endorse the General Assembly's decision to keep the Evansville Psychiatric Children's Center operational; and be it further,
RESOLVED, that if any state agency/official or private organization attempts to encourage closure of the Evansville Psychiatric Children's Center, the ISMA will use its resources to discourage this, so long as it sees a continued need for the facility in Indiana.

(RESOLUTION 09-19) RESOLVED, that the ISMA shall continue to support efforts to raise awareness of post-traumatic stress disorder and other associated psychiatric disorders related to the stresses involved with military personnel and their families; and be it further,
RESOLVED, that the ISMA continue to encourage physicians throughout the state to query patients and their families regarding stresses related to military deployments; and be it further,
RESOLVED, that the ISMA encourage development of a post-traumatic stress disorder screening tool to be placed on the ISMA Web site for physicians to use in their practice; and be it further,
RESOLVED, that the ISMA Delegation present a resolution to the 2010 AMA House of Delegates focusing attention, raising awareness, encouraging development of a screening tool, educating physicians, disseminating information and expediting treatment for military members and their families affected by stress disorders.

(RESOLUTION 08-30) RESOLVED, that the ISMA support efforts to raise awareness of post-traumatic stress disorder (PTSD) and other associated psychiatric disorders related to the stresses involved with military personnel and their families; and be it further,
RESOLVED, that the ISMA encourage physicians throughout the state to query patients and their families regarding stresses related to military deployments; and be it further,
RESOLVED, that the ISMA publish in *ISMA Reports* information regarding resources that are available for the assistance of military members and their families.

METHADONE /NARCOTICS

(RESOLUTION 17-39) RESOLVED, the ISMA send this resolution to the AMA House of Delegates to support complete state control of all aspects of methadone clinic approval and operations; and, if deemed necessary, this control could be granted on a state by state basis; and be it further

RESOLVED, the ISMA restate some of our current methadone clinic policies and add new ones as follows:
1) The medical director of an Indiana-based methadone clinic should be licensed in Indiana and have admitting privileges at a local hospital that is most appropriate for this patient population.
2) Indiana-based methadone clinics should have substantial counseling and drug rehab programs with the expectation that these would occur with every visit.
3) Indiana-based methadone clinics may benefit from limiting the number of clients served because of the logistics and efficiency issues that come in a crowded clinic operation.
4) Indiana-based methadone clinics should be required to periodically taper opioids provided to their clients. Pregnant clients should be tapered or referred to a program that specializes in managing pregnancy in opioid-addicted women.
5) All opioids dispensed by Indiana-based methadone clinics should be reported to INSPECT, along with a periodic INSPECT query.

(RESOLUTION 16-28) RESOLVED, that the ISMA support appropriate laws and/or policy to be propagated to assure that physicians are routinely notified of narcotic overdose or death of patients for whom they have prescribed narcotics in the preceding six months.

(RESOLUTION 12-25A) RESOLVED, that the ISMA take action it deems appropriate to seek and support legislation banning clinics for the maintenance of opioid addiction with methadone in Indiana; and be it further RESOLVED, that the ISMA support the continued availability of methadone in Indiana for the treatment of chronic pain but not necessarily as a drug of first choice.

(RESOLUTION 11-06) RESOLVED, that the ISMA encourage legislation to require methadone clinics operating in Indiana to enter prescribing data into INSPECT.

(RESOLUTION 11-05) RESOLVED, that the ISMA seek legislation to regulate methadone clinics in Indiana, to identify those clients who are pregnant and supply them with accurate information about the effects of methadone on fetus development, and to educate pregnant clients on neonatal abstinence syndrome.

(RESOLUTION 08-06A) RESOLVED, that the ISMA support legislation that requires methadone clinics to check their databases against INSPECT to ensure no simultaneous treatment of their patients by other physicians; and be it further,
RESOLVED, that the ISMA work with our AMA delegation to change the federal statute to allow states the flexibility to require methadone clinics to report to programs like INSPECT.

(READOPTED 17-18, RESOLUTION 07-15A) RESOLVED, that the ISMA support inclusion of methadone clinic patients in the INSPECT program; and be it further,
RESOLVED, that the ISMA support development of a statewide physician narcotic educational program with prescribing and patient monitoring guidelines.

NURSING

(RESOLUTION 08-35) RESOLVED, that the ISMA work with a legislator in the Indiana General Assembly to author a bill that would enact a state statute that would limit the number of full-time equivalent nurse practitioners that any one physician could legally collaborate with at any one time to four, the purpose of which is to maintain good quality medical care in Indiana; and be it further,
RESOLVED, that the ISMA refer this resolution to the AMA to develop national policy.

(11/23/80, BOT) Supports retention of hospital-based, three-year nursing programs, as well as other levels of nursing education, until the results of studies on nursing supply are available to define a course of action.

NURSING HOMES

(RESOLUTION 13-46) RESOLVED, that the ISMA work at the state and national level with The Center for Medicare Advocacy (who supports this change) to eliminate the distinction between in-patient and observation status, so that all time spent in the hospital counts toward the skilled nursing and nursing home coverage.

(RESOLUTION 08-03) RESOLVED, that the ISMA encourage nursing home patients to receive a minimum of 1000 units of vitamin D every day and educate physicians and nursing home personnel appropriately.

ORGAN DONATION/TRANSPLANTS

(READOPTED 12-34, HOD; RESOLUTION 02-6) RESOLVED, that the ISMA encourage all physicians and more Hoosiers to become organ donors.

(READOPTED 09-56, HOD; RESOLUTION 99-24) RESOLVED, that the ISMA through local medical societies increase awareness about organ donation by encouraging their physician members, their staffs and their patients to discuss their wishes about organ donation with their family members to ease the family's decision at the time of death.

PATIENT-CENTERED MEDICAL HOME

(RESOLUTION 12-11) RESOLVED, that the ISMA support the Joint Principles of the Patient-Centered Medical Home as a guideline for states to improve the health of their citizens; and be it further,
RESOLVED, that the ISMA encourage Medicaid and other payers to implement and fund programs that demonstrate the quality, safety, value and effectiveness of the patient-centered medical home, and to reward efficient programs.

PEER REVIEW

(RESOLUTION 13-43) RESOLVED, that the ISMA pursue legislation that would:

- Require private insurers to assign an appropriate equal-level specialty or subspecialty for peer-to-peer reviews.
- Require a $100 fee made payable to a physician from a private insurance company that is forced into a "peer-to-peer" review in order to defend the "medical necessity" of the procedure that was ordered by the treating physician on behalf of his/her patient.

(RESOLUTION 08-36) RESOLVED, that the ISMA adopt the following AMA policies on peer review:

E-9.05 Due Process

The basic principles of a fair and objective hearing should always be accorded to the physician or medical student whose professional conduct is being reviewed. The fundamental aspects of a fair hearing are a listing of specific charges, adequate notice of the right of a hearing, the opportunity to be present and to rebut the evidence, and the opportunity to present a defense. These principles apply when the hearing body is a medical society tribunal, medical staff committee, or other similar body composed of peers. The composition of committees sitting in judgment of medical students, residents, or fellows should include a significant number of persons at a similar level of training. These principles of fair play apply in all disciplinary hearings and in any other type of hearing in which the reputation, professional status, or

livelihood of the physician or medical student may be negatively impacted. All physicians and medical students are urged to observe diligently these fundamental safeguards of due process whenever they are called upon to serve on a committee which will pass judgment on a peer. All medical societies and institutions are urged to review their constitutions and bylaws and/or policies to make sure that these instruments provide for such procedural safeguards. (II, III, VII) Issued prior to April 1977; Updated June 1994.

H-375.984 Peer Review

Our AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared with the credentialing body is protected by statute or regulation as confidential peer review information. Quality of care and patient safety are the goals of peer review. Peer review should address the prevention of medical errors and appropriate system changes. (Sub. Res. 93, A-88; Reaffirmed: Sunset Report, I-98; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-225.992 Right to Relevant Information

(1) The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff member's credential file, believes that any health care organization file on a physician should be opened to him or her for inspection, and supports inclusion of these provisions in hospital medical staff bylaws.

(2) Triggers that initiate a peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied to all cases and physicians.

(3) A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures and faced with potential peer review action shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond.

(4) All relevant information pertaining to a potential peer review action should be obtained promptly from the subject physician and other relevant sources. Relevant information includes, but is not limited to, pre-event factors, names of other health professionals involved in the care of the patient, and the contributing environmental factors of the health care facility/system.

(5) All material information obtained by the peer review committee regarding the subject of the peer review should be made available to the physician under review in a timely manner prior to the hearing.

(6) The investigating individual or body shall interview the practitioner, unless the practitioner waives his/her right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process. (Res. 121, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Modified by Sub. Res. 801, A-94; Reaffirmed: CLRPD 1, A-04; Amended with change in title: BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-375.965 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations

AMA policy is that:

(1) Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, or before the time in which a report would be required to the state licensing agency if applicable, whichever is shorter, to review and consider the summary suspension. The MEC shall then promptly modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing. If the MEC sustains the suspension, said action will trigger the fair hearing procedures contained in these policies.

(2) At the request of a medical staff department or of a member under review, or at its own initiative if needed for adequate and unbiased review, the medical executive committee may arrange, through the state or local medical society, the relevant specialty society or other appropriate source, for an external hearing panel to hear the case in order to assure professional and impartial clinical assessment.
(3) Prior to any disciplinary hearing, the physician should be provided with a clear, and if applicable, clinically supported basis for the proposed professional review action. A hearing panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in its review actions.
(4) Physician health and impairment issues should be identified and managed by a medical staff committee, which should operate separately from the disciplinary process. (BOT Action in response to referred for decision BOT Rep. 23, A-05)

E-9.10 Peer Review

Medical society ethics committees, hospital credentials and utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary, and committees performing such work act ethically as long as principles of due process (Opinion 9.05, "Due Process") are observed. They balance the physician's right to exercise medical judgment freely with the obligation to do so wisely and temperately. (II, III, VII) Issued prior to April 1977; Updated June 1994.

H-375.990 Peer Review of the Performance of Hospital Medical Staff Physicians

Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty. (Res. 57, I-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmed: BOT Rep. 8, I-01; Amended: BOT Action in response to referred for decision BOT Rep. 23, A-05)

H-375.970 Professional Review Organization Peer Review

The AMA strongly recommends that public and private sector review entities conduct their reviews using evidence-based guidelines or practice parameters developed by national medical specialty societies. (Sub. Res. 719, I-97; Reaffirmation I-98)

(READOPTED 08-13, HOD; RESOLUTION 98-20) RESOLVED, that the ISMA continue to support the confidentiality of peer review information.

(3-22-81, BOT) That peer review of physicians be done by physicians rather than by administrative or third-party carrier interests.

PHARMACEUTICALS

(RESOLUTION 16-29) RESOLVED, that the ISMA seek pharmacy board regulation or, if necessary, legislation and involve other interested parties to require locations that dispense medications to have a mechanism for patients to return unused medications; and be it further
RESOLVED, that such disposal shall be at no additional cost or significant inconvenience to the patient.

(RESOLUTION 16-28) RESOLVED, that the ISMA support appropriate laws and/or policy to be propagated to assure that physicians are routinely notified of narcotic overdose or death of patients for whom they have prescribed narcotics in the preceding six months.

(RESOLUTION 15-25) RESOLVED, that the ISMA House of Delegates work with the governor, legislature, or appropriate state agencies to review the structure and function of the Indiana State Board of Accounts with the

goal of improving the board such that its recommendations are more practical and workable, while promoting accurate accounting and decreasing the risk of loss.

(RESOLUTION 14-30) RESOLVED, that short-term urgent refills should be allowed once a month for certain critical medications when authorization is not readily available after hours, on weekends and on holidays, and that this recommendation be sent to the Food and Drug Administration and other vested parties, and ask that the same parties generate a list of critical medications qualifying for a five-day urgent refill; and be it further
RESOLVED, that the AMA generate model state legislation to allow short-term urgent refills for certain critical medications as often as once a month.

(RESOLUTION 13-32) RESOLVED, that the ISMA seek regulation or legislation requiring insulin to be available by prescription, and be it further
RESOLVED, that the ISMA delegation as the AMA to seek federal regulation or legislation requiring insulin be available by prescription and to encourage individual states to seek regulations or legislation requiring prescriptions for insulin.

(RESOLUTION 13-24) RESOLVED, that the ISMA support the "Prescribers Toolkit" concepts published by the Office of Indiana Attorney General Indiana Prescription Drug Abuse Prevention Task Force and its subcommittee on education.

(RESOLUTION 13-17) RESOLVED, that the ISMA membership endorse emergency rules addressing responsible opioid prescribing as proposed by the ISMA, the Office of the Indiana Attorney General, the American Association of Pain Management and other stakeholders.

(RESOLUTION 13-03) RESOLVED, that the ISMA support legislation in the Indiana General Assembly to include tramadol as a Class IV controlled substance.

(RESOLUTION 11-40) RESOLVED, that the AMA promote policies to prevent fraudulent prescriptions, such as by having the pharmacy notify the "prescribing" physician each time a controlled substance is dispensed or by assigning physicians a unique code number that must accompany each controlled prescription. This code number would be changed periodically; and be it further,
RESOLVED, that the AMA promote and facilitate the establishment of controlled substances tracking programs in all states, the free exchange of controlled substance prescription data between all states, and the tracking of all controlled substance classes; and be it further,
RESOLVED, that the AMA promote and facilitate a change of federal rules and regulations such that methadone clinics would report methadone dispensed for outpatient use to their appropriate state-controlled substance prescription tracking program; and be it further,
RESOLVED, the AMA encourage the Veterans Administration and Department of Defense facilities to report outpatient controlled substance prescriptions to their appropriate state-controlled substance prescription tracking program; and be it further,
RESOLVED, that the AMA promote and facilitate rules and regulations in all states that require reporting of veterinarian-controlled substance prescriptions with the prescription assigned to the owner of the animal and the individual who picks up the prescription; and be it further,
RESOLVED, that the AMA encourage states to require hospital pharmacies to report outpatient controlled substance prescriptions to the appropriate tracking program; and be it further,
RESOLVED, that the AMA encourage states to publicize their controlled substances prescription data for the edification of the public and drug policy makers; and be it further,
RESOLVED, that the AMA maintain its important role for physicians by: 1) promoting physician training and competence on the proper use of controlled substances; 2) encouraging physicians to use screening tools (such as NIDAMED) for drug use in their patients; 3) providing references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; 4) encouraging physicians to use opiate and other controlled substances contracts with their patients; and 5) encouraging physicians to query their state's controlled substances databases for information on their patients on controlled substances; and be it further,

RESOLVED, that this resolution (11-40) will be sent to the AMA for discussion and consideration if adopted by the ISMA House of Delegates.

(RESOLUTION 11-34) RESOLVED, that the ISMA support a legislative and/or administrative remedy that requires all pharmacies to provide their pharmacists access to the Indiana INSPECT program website; and be it further,
RESOLVED, that the ISMA continue to educate and encourage physicians and other providers to use the INSPECT program to review controlled substances prescription histories of their patients who are prescribed controlled substances.

(READOPTED 10-64, HOD; RESOLUTION 00-37) RESOLVED, that the ISMA continue to support the concept of a voluntary regional drug depository; and be it further,
RESOLVED, that the ISMA educate its membership and other interested parties about the concept of a voluntary regional drug depository.

(RESOLUTION 10-14) RESOLVED, that the ISMA work with the appropriate state and federal agencies to modify INSPECT so that individual physicians can query, but not be required to query, their individual DEA numbers and see what prescriptions have been filled by whom under their prescribing authority.

(READOPTED 09-60, HOD; RESOLUTION 99-51) RESOLVED, that the ISMA support or initiate legislation to change the present requirements governing the providing of prescription medication (not controlled substances) that would allow free or reduced fee health care facilities the opportunity to provide pharmaceutical services.

(READOPTED 09-53, HOD; READOPTED 99, HOD; RESOLUTION 86-27) RESOLVED, that the ISMA completely and officially oppose the use of anabolic steroids for nonmedical use.

(READOPTED 09-52, HOD; READOPTED 99, HOD; RESOLUTION 87-18) RESOLVED, that the ISMA oppose any legislative or regulatory attempts that would deny the physician the legal and professional right to dispense medications from the office, and that the ISMA would continue to keep its members informed about the proper guidelines and procedures for dispensing medications from the office.

(READOPTED 09-51, HOD; READOPTED 99, HOD; RESOLUTION 89-18) RESOLVED, that the ISMA endorse the concept of a drug-free Indiana and lend its support and expertise to attain this goal when asked to participate.

(READOPTED 09-46, HOD; READOPTED 99, HOD; RESOLUTION 76-1) RESOLVED, that the ISMA oppose generic substitution for a prescribed drug done at the discretion of a pharmacist.

(RESOLUTION 08-31A) RESOLVED, that the ISMA support the Indiana Pharmacists Alliance's development of a system that will accommodate the needs of patients who present with a legally written prescription or request a non-prescription drug that is required to be stored behind the pharmacy counter.

(RESOLUTION 08-25) RESOLVED, that the ISMA collaborate with other agencies and organizations to educate Hoosiers about prescription medicine abuse; and be it further,
RESOLVED, that the ISMA inform Hoosier physicians of the magnitude of prescription medicine abuse with helpful hints to reduce abuse, such as talking to patients about the handling and safe-keeping of drugs, using INSPECT, etc.; and be it further,
RESOLVED, that the ISMA collaborate with pharmacists, pharmacies and pharmaceutical companies and organizations to reduce prescription medicine abuse; and be it further,
RESOLVED, that the ISMA study the role of prescription medicine abuse from Internet sales and report to the 2009 ISMA House of Delegates via resolution/report if appropriate.

(RESOLUTION 08-19) RESOLVED, that the ISMA seek legislation to require the Medicaid program and private insurance companies to use electronic drug formularies and to provide financial incentives to encourage the use of e-prescribing by physicians.

(RESOLUTION 07-04) RESOLVED, that the ISMA support full disclosure by all participants who formulate clinical practice guidelines of their relationships with pharmaceutical and medical device industries.

(1/21/98, BOT) Reaffirmed support for the current generic substitution statute.

(1/17/96, BOT) Approved not opposing the following policy regarding pharmacists:

- That drug therapy management should be limited to acute care hospitals.
- Pharmacists should not manage hyperalimentation.
- Drug therapy management may occur only when the physician acts to allow it.

(4/10/88, BOT) Registered opposition to the multiple copy prescription program; but if the program goes into effect, the 10 recommendations, as outlined in the April 10 "Suggested Report" from the ISMA Department of Government Relations, be submitted to the Education Forum Subcommittee, the Prescription Pad Subcommittee, as well as the Prescription Abuse Study Committee for consideration.

(1/17/88, BOT) Approved the restriction of amphetamine use in that Schedule II not be used for weight control and that Schedules III and IV (anorectic) be limited in their use, to be determined by the Indiana Medical Licensing Board.

PHYSICAL THERAPISTS (PTs)

(READOPTED 10-50, HOD; RESOLUTION 00-38) RESOLVED, that the ISMA oppose the concept of direct access to physical therapists without a prescription for therapy from a physician.

PHYSICIAN AS HEALTH ADVOCATE

(RESOLUTION 11-14) RESOLVED, that the ISMA continue its policy to offer the Indiana Attorney General's Office, and other interested agencies, volunteer physicians who can serve to render consultations to these agencies free of charge and in an expeditious manner.

(READOPTED 10-45, HOA; RESOLUTION 00-03) RESOLVED, that the ISMA each year sponsor a physician on a medical mission trip; and be it further,
RESOLVED, that the physician be chosen by lottery from nominations from county alliances and medical societies.

(RESOLUTION 10-26) RESOLVED, that the ISMA support efforts to ban in Indiana the sale and use of herbal products, also known as synthetic marijuana and 'spice,' as well as other similar products; and be it further,
RESOLVED, that the ISMA urge the AMA to support federal regulation of herbal products, also known as 'spice,' as well as other similar products, and support efforts to ban the sale and use of such products in the USA.

(RESOLUTION 08- 46) RESOLVED, that the ISMA ask the AMA to seek FDA regulation of energy drinks, to include a maximum caffeine content per ounce as well as caffeine content and health warnings to be listed on the label.

(RESOLUTION 08-44) RESOLVED, that the ISMA create a position statement to encourage accelerated improvements in the built community throughout Indiana to reduce obesity as a matter of public health. The Monon Trail (Indianapolis) and the B-line (being built in Bloomington) serve as positive examples.

PHYSICIAN, USE OF THE TERM

(3/22/98, BOT) Supported a proposal calling for the ISMA to petition the Indiana legislature to enact legislation that would limit the use of the term "physician" to only those practitioners who hold degrees of doctor of medicine or doctor of osteopathy.

PHYSICIAN ASSISTANTS (PAs)

(RESOLUTION 12-20) RESOLVED, that the ISMA endorse the AMA suggested "Guidelines for Physician/Physician Assistant Practice;" and be it further,
RESOLVED, that the ISMA work with the Indiana Academy of Physician Assistants to enhance patient care through effective collaboration between physicians and physician assistants.

(7/8/87, EC) Endorsed the concept for the necessity of PA rules with emphasis toward improving supervision of PAs and that the diagnosis or the prescription for drugs, etc., should originate with the physician.

PHYSICIAN-ASSISTED SUICIDE

(RESOLUTION 16-12) RESOLVED, that the ISMA affirm its support against physician-assisted suicide as stated in the AMA Code of Ethics; and be it further
RESOLVED, that the ISMA oppose legislation advocating physician-assisted suicide.

PHYSICIAN EMPLOYMENT

(RESOLUTION 17-28) RESOLVED, that ISMA support best practice for physician employment that will promote improved work-life balance and maximal employment adaptability and professional treatment to maintain physicians in productive medical practice and minimize physician burnout. To achieve these goals, best practice efforts in physician employment contracts would include, among other options:

1. Establishing the degree of physician medical staff support as well as specifying how different medical staff costs will be covered.
2. Establishing a specific degree of clerical and administrative support. This would include access to an EMR (electronic medical record) scribe, as well as specifying how different clerical or administrative support costs will be shared/covered.
3. Providing information regarding current EMR systems and their national ranking, including user ratings and plans to improve these systems.
4. Providing work flexibility with pay and benefit implications for reduced work hours, reduced call coverage, job sharing, child care support, use of *locum tenens* coverage, leave of absence for personal reasons or extended duty in the military, medical service organizations or other "greater societal good" organizations.
5. Establishing an expected workload that does not exceed the mean RVU production of the specialty in that state/county/region; and be it further

RESOLVED, that Resolution 17-28 is referred through our Indiana AMA Delegation to both the Organized Medical Staff Section (OMSS) of the AMA and to the AMA House of Delegates before the 2018 AMA Annual Meeting.

PHYSICIAN HEALTH OFFICERS

(READOPTED 09-48, HOD; READOPTED 99, HOD; RESOLUTION 86-48) RESOLVED, that the ISMA continue to support statutory provisions that require the local health officer to be a physician with an unlimited license to practice medicine in Indiana.

PHYSICIAN IDENTIFICATION

(RESOLUTION 17-12) RESOLVED, that because professional abbreviations are increasingly complex and confusing, they should not be used on health professional ID tags; and be it further
RESOLVED, that nationally standardized whole word labels should be used on health professional and health worker ID tags; and be it further
RESOLVED, that these recommendations will be sent to the AMA House of Delegates for consideration and adoption.

(RESOLUTION 15-44) RESOLVED, that the ISMA seek to encourage all physicians practicing medicine in Indiana to wear an identification badge that is clearly visible and reads "physician"; and be it further
RESOLVED, that the ISMA provide education to its members, patients and other appropriate stakeholders regarding the importance of clearly identifying physicians in various practice settings; and be it further
RESOLVED, that the ISMA provide marketing support to inform the public of the importance of and identification of physicians who care for them; and be it further
RESOLVED, that the ISMA provide physician identification badges free of charge to current members and make the badges available for purchase to nonmember physicians.

(RESOLUTION 07-26A) RESOLVED, that the ISMA adopt AMA Policy H-360.986 Professional Nurse Staffing in Hospitals (3) encouraging medical and nursing staffs to use identification mechanisms, e.g. badges, that provide the name, credentials and/or title of the physicians, nurses, allied health personnel and unlicensed assistive personnel in facilities to enable patients to easily note the level of personnel providing their care.

PHYSICIAN PROFILING

(3/22/98, BOT) Supported the following:
- ISMA members recognize that the public, our patients, have a right to be informed of their physicians' qualifications.
- The ISMA should explore the possibility of a voluntary, physician-sponsored program of physician profile data release to the public.
- The ISMA should use as its possible model the voluntary physician-profiling program of the Colorado State Medical Society.

PHYSICIANS – SURGEONS

(READOPTED 09-47, HOD; READOPTED 99, HOD; RESOLUTION 86-47) RESOLVED, that the ISMA encourage the membership to provide postoperative care in accordance with the ethics of the medical profession and to report to the Medical Licensing Board any violations of the standards of practice of medicine.

(7-31-94, BOT) Supported the ISMA recommending to the Medical Licensing Board adoption of the following language:
- General Responsibilities of the Surgeon - The ultimate responsibility for diagnosing medical and surgical problems is that of the licensed doctor of medicine or osteopathy who is to perform the surgery. The operating surgeon is responsible for all surgical decisions and remains responsible for all treatment decisions. Pre-operative evaluation and postoperative management as well as the surgical procedure constitute the practice of medicine.
- Pre-operative Responsibilities – The surgeon is responsible for pre-operative evaluation of the patient. That includes obtaining a review of the patient's history, performing an adequate pre-operative exam and making an independent diagnosis. In addition, it is the responsibility of the operating surgeon or

an equivalently licensed doctor of medicine or osteopathy (or a physician practicing within a board-approved post-graduate training program) to explain the procedure to the patient and obtain informed consent. However, it is not necessary that the operating surgeon witness the signature of the patient on the written form evidencing informed consent.

- Postoperative Responsibilities – The postoperative recovery period is defined as the length of time required to assure that the occurrence of complications from the surgery is minimal. Postoperative management is defined as all the treatment decisions made during the postoperative recovery period, as based upon the operating surgeon's personal observations and professional judgment. The postoperative responsibilities of the operating surgeon include, but are not limited to: (1) monitoring of the patient during the recovery process; (2) detecting and diagnosing conditions arising during the recovery process; (3) adjusting of medications; and (4) treating post-surgical complications. The operating surgeon is responsible for the coordination of overall patient care during the postoperative period until the patient has recovered from the surgery.
- Delegation of Postoperative Responsibilities – The surgeon may delegate certain discretionary postoperative management activities to equivalently licensed doctors of medicine or osteopathy (or to a physician practicing within a board-approved post-graduate training program) under the following specific conditions:
  - Postoperative care may not be delegated to any other health care practitioner except under the direct on-premise supervision of the operating surgeon or equivalently licensed doctor of medicine or osteopathy (or a physician practicing within a board-approved post-graduate training program).
  - If the surgeon is unable to personally render postoperative care due to an unusual event, such care must, when possible, be delegated by pre-arranged agreement with the patient. This care should be delegated to another equivalently licensed doctor of medicine or osteopathy (or to a physician practicing within a board-approved post-graduate training program).
- All licensed physicians have an ethical obligation to report instances of surgeons routinely delegating postoperative management to non-physicians.

(9/20/87, BOT) That the postoperative care of surgical patients constitutes the practice of medicine and should be performed only by unlimited practitioners (M.D. or D.O.) or under their direct supervision and control. It is, therefore, the policy of the ISMA to encourage its membership to provide postoperative care in accordance with good medical practice and not to allow inappropriate postoperative care to be provided by limited practitioners without proper supervision by an unlimited practitioner (MD or DO).

PROVIDER, USE OF THE TERM

(READOPTED 09-59, HOD; RESOLUTION 99-40) RESOLVED, that the ISMA oppose use of the term "provider" or "health care provider" to refer to a physician, and that our delegates to the AMA pursue remedies on a national level to correct this misuse of these terms.

REPRODUCTIVE HEALTH

(RESOLUTION 17-41) RESOLVED, the ISMA support legislation creating a maternal mortality review program in Indiana. This program will allow confidential collection, investigation and review of maternal mortality in Indiana to develop strategies to prevent future maternal-related mortality.

(RESOLUTION 17-02) RESOLVED, that ISMA petition the secretary of the Indiana Family and Social Services Administration and the commissioner of the Indiana Department of Insurance to require Medicaid and insurance companies to provide and compensate providers' offices for one nurse-education visit in the early second trimester of pregnancy and one nurse-education visit in the early third trimester of pregnancy to discuss signs and symptoms of preterm labor, preterm premature rupture of membranes, incompetent cervix and the

dangers to an infant of low or very low birth weight. Reimbursement would be in addition to the global prenatal care reimbursement.

(RESOLUTION 13-34) RESOLVED, that the ISMA actively support and encourage appropriate screening of all pregnant women in Indiana for legal and illegal use of prescription medications and other substances that might adversely affect their health, their pregnancies or the health of their fetuses, including alcohol and tobacco, through use of the aforementioned evidence-based, validated screening tools and motivational counseling; and be it further
RESOLVED, that the ISMA develop policy to actively support and encourage pregnant substance users by:

- Encouraging appropriate medical care, rather than criminalization
- Encouraging management and referral of services appropriate to their needs
- Identifying and developing adequate addiction treatment services
- Encouraging better reimbursement for addiction treatment services
- Encouraging addiction treatment programs to accept pregnant women

And be it further,
RESOLVED, that the ISMA actively support and encourage an educational program for all Indiana physicians regarding prevention, validated screening, motivational counseling and evidence-based treatment of pregnant women for the legal and illegal use of prescription medications and other substances potentially harmful to them and their fetuses, including alcohol and tobacco.

(RESOLUTION 10-68) RESOLVED, that the ISMA Board of Trustees send a letter to the Medical Licensing Board to allow but not require Expedited Partner Therapy (EPT) for chlamydia and gonorrhea, according to current Centers for Disease Control and Prevention (CDC) recommendations for EPT, by modifying Rule 4 to include EPT; and be it further,
RESOLVED, that the ISMA policy now include the policy statement in support of legislation in Indiana of Expedited Partner Therapy (EPT), according to current CDC recommendations

(READOPTED 10-62; RESOLUTION 00-42) RESOLVED, that the ISMA support the present Indiana ban or any future ban regarding partial birth abortion, except in situations where the mother's life is endangered.

(RESOLUTION 10-09) RESOLVED, that the ISMA public policy include support for education regarding the role of HPV in lower genital tract neoplasia, and the availability of effective vaccination as an essential component of comprehensive sex education.

(RESOLUTION 10-08) RESOLVED, that the ISMA endorse the public health goal of substantially reducing the rate of teen pregnancy and unintended pregnancy at any age in Indiana via public education and professional awareness.

(RESOLUTION 10-03) RESOLVED, that the ISMA support a ban on the sale of over-the-counter prenatal gender prediction tests, such as Intelligender, and direct-to-consumer prenatal gender-prediction tests, such as Baby Gender Mentor.

(RESOLUTION 07-20) RESOLVED, that the ISMA support state legislation that requires all facilities in Indiana rendering emergency care to provide the following services to sexual assault patients:

1. Treatment of trauma
2. Testing and prophylaxis for sexually transmitted disease
3. Collection of forensic evidence
4. Accurate, factual information about emergency contraception for patients capable of pregnancy

(1/14/90, BOT) Reaffirmed its abortion policy that "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 laws of the state. No physician or other professional personnel shall be required to perform an act violative of good medical judgment 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." (This policy differs from the AMA's policy that was amended in December 1989 to include a third paragraph that reads: "The American Medical Association supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent and the availability of appropriate facilities.")

RESIDENCIES

(READOPTED 09-49, HOD; READOPTED 99, HOD; RESOLUTION 89-44) RESOLVED, that the ISMA support the need to limit resident duty hours to: (1) 80 hours per week, averaged over a four-week period, inclusive of all in-house call activities, (2) with one day in seven free from all educational and clinical responsibilities, averaged over a four-week period, (3) a 10-hour time period be provided between all daily duty periods and after in-house call, and (4) no more than 24 consecutive hours for on-site duty, including in-house call, with the allowance that residents may remain on duty for up to six additional hours to participate in didactic activities, transfer care of patients, conduct outpatient clinics and maintain continuity of medical and surgical care; and be it further,
RESOLVED, that the ISMA only support future reductions in resident duty hours that are based on sound, validated research regarding its direct impact on patient health and safety and/or resident safety.

RESTRICTIVE COVENANTS

(READOPTED 09-58, HOD; RESOLUTION 99-33) RESOLVED, that the ISMA continue to endorse the AMA's policy on restrictive covenants.

The AMA CEJA policy (E-9.02) states:
Covenants not to compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (Issued prior to April 1977; Updated June 1998.)

SCHOOL NUTRITION, HEALTH AND SAFETY

(READOPTED 15-19, HOD; RESOLUTION 05-06) RESOLVED, that the ISMA work with schools to encourage programs to educate and promote a more active and healthy lifestyle, with special attention given to children, and be it further,
RESOLVED, that the ISMA discourage active promotion of unhealthy food, drinks and lifestyle in schools.

(READOPTED 15-11, HOD; RESOLUTION 05-27) RESOLVED, that the ISMA encourage county medical societies to collaborate with their local medical Alliance and other organizations to create and implement focused educational activities to prevent steroid and other potentially harmful supplement use in school and community environments; and be it further,
RESOLVED, that the ISMA encourage physicians to discuss this topic with their adolescent patients.

(READOPTED 15-06, HOD; RESOLUTION 05-28) RESOLVED, that the ISMA support legislation providing for the availability for all high school and middle school students of a comprehensive program of sexuality education. Approved programs should:

- Be based on rigorous, peer-reviewed science
- Show potential for delaying the onset of sexual activity and reduction of high-risk behavior for contraction of STDs
- Teach responsible sexual behavior

- Show potential for reducing rates of unintended pregnancy
- Encourage parental involvement in school sexual education

(RESOLUTION 14-42) RESOLVED, that the ISMA support and encourage measurement of height-weight (coupled with age and gender) in all school children (K-12) while protecting the confidentiality of the individual child; and be it further
RESOLVED, that the ISMA support the use of this data by the state in determining the overweight and obesity prevalence in children so as to provide yearly cross-sectional and longitudinal epidemiological data; and be it further
RESOLVED, that the ISMA support the development of a state plan to collect and disseminate this data.

(READPOTED 14-41; RESOLUTION 04-24) RESOLVED, that the ISMA support the reintroduction of legislation that would provide more nutritious selections in food and beverage vending machines in schools; and be it further,
RESOLVED, that the ISMA support requiring 30 minutes of daily physical activity for elementary school students in public schools.

(READOPTED 14-40; RESOLUTION 04-12) RESOLVED, that the ISMA recommend to Indiana physicians that Body Mass Index (BMI) be incorporated in the examination of children and youth aged 2 to 20; and be it further,
RESOLVED, that the ISMA discuss with the Indiana State Department of Health the inclusion of BMI data in the Children and Hoosiers Immunization Registry Program database, and be it further,
RESOLVED, that the ISMA work with appropriate organizations to develop a source of BMI charts available to physicians that include growth charts for ages 2 to 20.

(READOPTED 14-39; RESOLUTION 04-42) RESOLVED, that the ISMA encourage county medical societies to work with their local school corporations to make them aware of the Action for Healthy Kids initiative as a means of addressing the nutrition and exercise needs of school children.

(READOPTED 14-38; RESOLUTION 04-23) RESOLVED, that the ISMA encourage county medical societies to work within their local school districts to see that automatic external defibrillators are placed in school districts in a central and accessible location near a telephone, according to recommendations in the American Heart Association Medical Emergency Response Plan for Schools.

(RESOLUTION 13-07) RESOLVED, that the ISMA seek legislation that would:
1. Allow schools to stock unassigned auto-injectable epinephrine for use in cases of life-threatening allergic reactions before, during and after school.
2. Allow school nurses (as defined by IC 20-34-5-9) or trained unlicensed school personnel (who have volunteered to be trained to recognize anaphylaxis and administer epinephrine) to administer stock auto-injectable epinephrine to students, staff or visitors with a known history of allergy who demonstrate signs and symptoms of life threatening anaphylaxis if their own epinephrine is not available.
3. Allow school nurses to administer stock auto-injectable epinephrine to students, staff, or visitors without a known history of allergy who demonstrate signs and symptoms of life-threatening anaphylaxis.
4. Allow school staff to volunteer to be trained in recognizing anaphylaxis and to administer stock auto-injectable epinephrine to students, staff or visitors without a known history of allergy who demonstrate signs and symptoms of anaphylaxis. Such training will be developed by physicians and offered to staff volunteers independent of the school nurses' role.
5. Grant immunity from liability, except in cases of willful or wanton misconduct, to school nurses and trained unlicensed personnel who administer epinephrine in good faith for suspected life-threatening allergic reactions.
6. Allow any licensed practitioner in Indiana to prescribe stock auto-injectable epinephrine for a school district. Such licensed practitioner shall be immune from civil liability for any act or omission related to administration of such epinephrine except in cases of willful or wanton misconduct.

(RESOLUTION 12-24) RESOLVED, that the ISMA seek legislation to change the Indiana school vision testing requirement to a more inclusive screening process to ensure all students are screened and those needing additional treatment receive it.

(RESOLUTION 12-08) RESOLVED, that the ISMA seek and support legislation amending existing law that supports daily physical activity in elementary schools to specify at least 30 minutes of daily structured physical activity, defined as activity directed by an educator, at an intensity to increase students' heart rate appropriate for their age and physical ability that will build endurance and strength.

(RESOLUTION 10-21) RESOLVED, that the ISMA develop a program or mailing to educate medical providers on identifying at-risk children and the reporting process; and be it further,
RESOLVED, that the ISMA continue to support legislation addressing bullying; and be it further,
RESOLVED, that the ISMA support community programs to educate parents and children regarding bullying.

(RESOLUTION 10-07) RESOLVED, that the ISMA endorse, as part of a comprehensive sex education program, instruction regarding the Indiana Safe Haven Law, and encourage both voluntary and legally mandated efforts to educate teens regarding laws for protection of newborns.

(11/2/08, BOT) Supported that the ISMA (referencing RESOLUTION 08-33A) promote physician education opportunities and offer continuing medical education credits for courses including:

- Reproductive medical care of teens
- Logistics and medico-legal issues of teen medicine
- Sexual behavior and public health
- Physicians' role in life-span comprehensive sexuality education

SCOPE OF PRACTICE – ALLIED PROVIDERS

(RESOLUTION 11-04) RESOLVED, that the ISMA work with the Medical Licensing Board of Indiana to encourage the Indiana attorney general to investigate that appropriate supervision of mid-level providers is occurring in retail health care clinic settings.

(RESOLUTION 10-24) RESOLVED, that the ISMA support legislation to direct the Indiana State Department of Health (ISDH) or seek direct contact with the ISDH to establish a way to track "trends" for non-regulated areas, such as the practice of midwifery and home deliveries by individuals not trained medically or not licensed as a physician or nurse midwife who perform procedures on patients/clients; and be it further,
RESOLVED, that the ISMA support legislation to direct the ISDH or to seek direct contact with the ISDH to establish a rule that requires immediate reporting to the local county health officer (or its representative) of adverse reactions resulting in hospital admission and/or death for the specific purpose of gathering data when a non-regulated person is performing midwifery or body modification.

(READOPTED 09-50, HOD; READOPTED 99, HOD; 1973, HOD) RESOLVED, that the ISMA oppose legislation that would authorize non-physicians to engage in the diagnosis or treatment of disease or injury, and unequivocally oppose and seek to defeat any legislation that would extend the scope of any allied health profession into the areas of the practice of medicine.

(7/8/87, EC) Endorsed the concept for the necessity of PA rules with emphasis toward improving supervision of PAs and that the diagnosis or the prescription for drugs, etc., should originate with the physician.

SPORTS MEDICINE (including IHSAA issues)

(RESOLUTION 13-09) RESOLVED, that the ISMA adopt policy that:

1. Discourages "heading" of the ball while playing soccer until the athlete is playing in an organized league, once in high school, and has been trained in the proper technique based upon contemporaneous standards
2. Recommends that individuals trained in heading the ball similarly train athletes when they are old enough
3. Encourages continued investigation by our local sports medicine, pediatric and neurological colleagues, into the potential consequences of nonconcussive heading involved with soccer participation; and be it further

RESOLVED, that the ISMA delegation to the AMA propose that the AMA adopt policy that:

1. Discourages "heading" of the ball while playing soccer until the athlete is playing in an organized league, once in high school, and has been trained in the proper technique based upon contemporaneous standards
2. Recommends that individuals trained in heading the ball similarly train athletes when they are old enough
3. Encourages continued investigation by our local sports medicine, pediatric and neurological colleagues, into the potential consequences of nonconcussive heading involved with soccer participation.

(READPOTED 11-51, HOD; RESOLUTION 01-27) RESOLVED, that the ISMA oppose mandatory pre-participation EKGs for all Indiana high school athletes.

(RESOLUTION 10-23) RESOLVED, that the ISMA urge the IHSAA to change the required date for preparticipation physical exams to no more than 365 days prior to the start of athletic participation to allow student athletes an opportunity to receive a comprehensive exam by their primary care provider and to provide ample time for appropriate follow-up.

(8/2/92, BOT; 10/19/84, BOT) Endorsed the recommendation of the ISMA Commission on Sports Medicine that Indiana High School Athletic Association (IHSAA) physical examinations be performed by physicians who have an unlimited license to practice medicine.

(6/7/87, BOT) Endorsed the recommendation from the Commission on Sports Medicine to promote equestrian safety by the use of protective headgear at all equestrian events.

TOBACCO

(RESOLUTION 16-45) RESOLVED, that the ISMA reaffirm its position that tobacco settlement funds should be used only for health-related programs.

(RESOLUTION 16-23) RESOLVED, that the ISMA reaffirm existing policy and support legislation to increase the tobacco tax by at least $1; and be it further
RESOLVED, that the ISMA reaffirm existing policy and support the prioritized and dedicated use of additional funds raised through an increased tobacco tax for health-related purposes, including tobacco cessation and addiction treatment; and be it further
RESOLVED, that the ISMA reaffirm existing policy and support legislation to raise the smoking age to 21; and be it further
RESOLVED, that the ISMA support legislation to repeal the Smokers' Bill of Rights.

(RESOLUTION 16-16) RESOLVED, that the ISMA support and seek rules/regulations/legislation to raise the minimum legal sale age to 21 for tobacco products and other nicotine delivery devices.

(RESOLUTION 15-42) RESOLVED, that the ISMA support public/physician education and appropriate public policy (using AMA policy as a framework) for Electronic Nicotine Delivery Systems/E-Cigs as more peer-reviewed research becomes available; and be it further

RESOLVED, that the ISMA support legislation that the use of any Electronic Nicotine Delivery Systems/E-Cig product should be restricted to citizens greater or equal to 21 years of age; and be it further
RESOLVED, that all existing ISMA policies addressing tobacco and tobacco products be construed to include Electronic Nicotine Delivery Systems/E-Cigs where applicable.

(READOPTED 15-20, HOD; RESOLUTION 05-07A) RESOLVED, that the ISMA continue its current efforts to support smoking cessation.

(READOPTED 12-19, HOD; RESOLUTION 02-8) RESOLVED, that the ISMA endorse the raising of the legal age to possess and use tobacco in Indiana; and be it further,
RESOLVED, that the ISMA inform its members and the citizens of Indiana of the health advantages of raising the legal age to possess and use tobacco; and be it further,
RESOLVED, that the ISMA collaborate with other agencies and organizations to support legislation in Indiana to raise the legal age to possess and use tobacco.

(READOPTED 11-22, HOD; RESOLUTION 01-14) RESOLVED, that the ISMA continue to support efforts to reduce tobacco use by supporting any efforts to increase the excise tax on tobacco products, no matter how the additional revenue is utilized by the state.

(READOPTED 11-17, HOD; RESOLUTION 01-30) RESOLVED, that the ISMA seek legislation to provide smoke-free workplaces in Indiana.

(RESOLUTION 10-51) RESOLVED, that the ISMA strongly oppose any legislative efforts that would abolish the Indiana Tobacco Prevention and Cessation Agency with its governing Executive Board or move it to the Indiana State Department of Health or other state agency.

(RESOLUTION 10-34) RESOLVED, that the ISMA support comprehensive legislation calling for smoke-free air in all workplaces including restaurants, bars and casinos to protect all employees; and be it further,
RESOLVED, that the ISMA become or continue as a supporting member of the Indiana Campaign for Smoke-free Air.

(READOPTED 10-33, HOD; RESOLUTION 00-28) RESOLVED, that the ISMA continue to support banning smoking and the use of all tobacco products at all Indiana elementary and secondary schools, on school properties, in all vehicles used for school-sponsored events and at all school-sponsored events.

(READOPTED 10-31, HOD; RESOLUTION 00-29) RESOLVED, that the ISMA continue to support funding for tobacco control efforts, as outlined by the CDC guidelines, from the monies Indiana received via the Master Settlement Agreement (i.e. tobacco settlement) and that monies from the Master Settlement Agreement be used for health-related issues.

(READOPTED 10-30, HOD; RESOLUTION 00-12) RESOLVED, that the ISMA continue to support efforts that would prohibit smoking in all day care centers.

(RESOLUTION 10-28A, HOD; AMENDED EXISTING POLICY RESOLUTION 00-29) RESOLVED, that the ISMA oppose the selling of any tobacco product by any pharmacies, or other health-related businesses, institutions, organizations or associations.

(RESOLUTION 10-05) RESOLVED, that the ISMA work with the AMA to encourage ratification of the World Health Organization's Framework Convention on Tobacco Control.

(READOPTED 09-13, HOD; RESOLUTION 99-31A) RESOLVED, that the ISMA again declare as policy that all monies derived from the tobacco settlement be used for health care and the promotion of community health including adequate state funding for tobacco use prevention and cessation as determined by CDC guidelines,

and that the ISMA continue to take a leadership role with other health care entities to ensure that tobacco settlement monies remain within the health care arena.

(READOPTED 09-11, HOD; READOPTED 99, HOD; RESOLUTION 79-2) RESOLVED, that the ISMA continue its policy of banning smoking during any of the association's business and educational activities; and be it further,
RESOLVED, that the ISMA prohibit the use of any tobacco products in facilities occupied by the ISMA; and be it further,
RESOLVED, that the ISMA attempt to hold all business and educational events in totally non-smoking surroundings.

(READOPTED 17-11, RESOLUTION 07-28) RESOLVED, that the ISMA establish policy and support legislation, rules and regulations that would ban smoking in public places in Indiana.

(READOPTED 17-10) RESOLUTION 07-27) RESOLVED, that the ISMA support legislation, policy, rules and regulations that would ban smoking in a vehicle with children; and be it further,
RESOLVED, that the ISMA seek and support legislation, policy, rules and regulations that would protect children in foster or guardianship care from second-hand smoke in enclosed areas.

(READOPTED 16-48, HOD; RESOLUTION 06-41) RESOLVED, that the ISMA actively support efforts to educate owners and managers of apartment complexes on the risks of secondhand smoke and methods to create smoke free buildings and common areas in their complexes; and be it further,
RESOLVED, that the ISMA actively support legislation to require that multi-building complexes provide an adequate number of smoke-free buildings to accommodate non-smoking residents, and be it further,
RESOLVED, that the ISMA also actively support methods and legislation to protect non-smokers in single building complexes (e.g. high rises) in as complete and cost-effective way as possible with the eventual goal of making such buildings entirely smoke-free.

(READOPTED 16-47, HOD; RESOLUTION 06-32) RESOLVED, that the ISMA support and encourage rules or regulations through the Department of Child Services and other agencies that all children placed in foster or guardianship care within the near future be protected from second-hand smoke within enclosed areas.

(READOPTED 16-23M HOD; RESOLUTION 06-12) RESOLVED, that the ISMA support legislation raising the Indiana state excise tax on cigarettes by at least $1 per pack; and be it further,
RESOLVED, that the ISMA encourage using the entire amount of any new tobacco tax revenue to create programs to help smokers quit and prevent recidivism as well as (for) other health care needs.

WOMEN IN MEDICINE, COMMITTEE ON

(RESOLUTION 10-43) RESOLVED, that the ISMA establish a Women in Medicine Committee with the purposes of:

- Increasing membership and participation of female medical students, residents and physicians in the ISMA
- Providing a forum for mentoring, leadership development and collegiality among Indiana women in medicine; and be it further,

RESOLVED, that the ISMA Bylaws be amended where appropriate to add the following:
Committee on Women in Medicine - The duties of this committee shall be to increase membership and participation of female medical students, residents, fellows and physicians in the ISMA and to provide a forum for mentoring leadership development and collegiality among Indiana women in medicine.