

RESOLUTION 09-01

STATEWIDE GUIDELINES FOR THE
ESTABLISHMENT OF BRAIN DEATH

Introduced by:

Emil L. Weber, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, reliable and consistent guidelines are essential for the establishment of brain death and facilitate the best possible end-of-life decisions for treating physicians, next-of-kin, and/or legal representatives; and

Whereas, the Indiana Organ Procurement Organization (IOPO) has found inconsistencies within the state for establishing brain death including: hospitals with no policy for the establishment of death, confusion regarding recognized definitions of brain death, inconsistencies in diagnostic protocols among physicians charged with determining death by neurological criteria and inappropriate use of radiologic agents for determining brain death; and

Whereas, new therapeutic interventions, i.e. hypothermia, barbiturate coma and hemicraniectomy complicate the present day brain death determination process; and

Whereas, most practicing physicians do not confront brain death determination issues in their day-to-day care of patients, reference guidelines serve as a valuable tool to help direct the process to obtain accurate diagnostic information for patient care decision-making; therefore, be it

RESOLVED, that the ISMA adopt brain death guidelines for adults and children, and a checklist for adults for use in Indiana medical facilities. (Proposed guidelines are attached.)

Proposed Guidelines for Brain Death Determination in the State of Indiana

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 $\geq 32^{\circ}$ C (90° F)
- 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 (4 mm) to dilated (9 mm)
- 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

3. Apnea – testing performed as follows:
- a) Prerequisites
 - i. Core temperature $\geq 36.5^{\circ}$ C or 97° F
 - ii. Systolic blood pressure ≥ 90 mm Hg
 - iii. Euvolemia. *Option:* positive fluid balance in the previous 6 hours
 - iv. Normal PCO_2 . *Option:* arterial $\text{PCO}_2 \geq 40$ mm Hg
 - v. Normal PO_2 . *Option:* preoxygenation to obtain arterial $\text{PO}_2 \geq 200$ mm Hg
 - b) Connect a pulse oximeter and disconnect the ventilator.
 - c) Deliver 100% O_2 , 6 l/min, into the trachea. *Option:* place a cannula at the level of the carina.
 - 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 ≤ 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 ≥ 60 mm Hg or PCO_2 increase is ≥ 20 mm Hg over baseline normal PCO_2 , the apnea test result is positive (it

supports the clinical diagnosis of brain death); if PCO_2 is < 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.

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, anticholinergics, antiepileptic drugs, chemotherapeutic agents, or neuromuscular blocking agents
- D. Sleep apnea or severe pulmonary disease resulting in chronic retention of CO_2

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 dimer (ECD, Biscite 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 $\text{PCO}_2 \geq 60$ mm Hg
- .
- E. Justification for confirmatory test and result of confirmatory test
- F. Optional: Repeat neurologic examination. The interval is arbitrary, but a 6-hour period is reasonable.
- G Document repeat neurological examination if performed.
- .

RESOLUTION 09-02

DIETARY REFERRALS FOR MEDICARE PATIENTS

Introduced by:

Caitilin Kelly, M.D.; Monroe/Owen County Medical Society; 2nd District Medical Society; ACP Indiana Chapter Health and Public Policy Committee

Referred to:

REFERENCE COMMITTEE IV

Whereas, globally there are more than one billion overweight adults and at least 300 million of them are obese; and

Whereas, obesity is a major risk for chronic disease, including type 2 diabetes, arthritis, gastroesophageal reflux disease, hypertension, stroke, cardiovascular disease, depression and certain forms of cancer; and

Whereas, education is one of the first steps to take in reversing this epidemic; and

Whereas, currently Medicare does not pay for referral to a dietitian for the diagnosis of obesity; therefore, be it

RESOLVED, that the ISMA encourage Medicare to make dietary referrals for the diagnosis of obesity a covered expense.

RESOLUTION 09-03

BACKGROUND CHECKS FOR ELDER CARE
APPLICANTS

Introduced by:

Caitilin Kelly, M.D.; Monroe/Owen County Medical Society;
2nd District Medical Society; ACP Indiana Chapter Health
and Public Policy Committee

Referred to:

REFERENCE COMMITTEE IV

Whereas, the elderly represent a very vulnerable population in the United States who often, as individuals and unlike children, lack advocates or family members who can supervise their care and ensure their safety; and

Whereas, recent studies have shown a disturbing number of eldercare applicants (people applying to work with the elderly in nursing home assisted care and home settings) have a history of violent felony conviction (7,000 in seven states in one three year study); and

Whereas, many of these applicants' criminal records are not picked up on the statewide background checks usually done, but would be picked up on a nationwide background check; therefore, be it

RESOLVED, that the ISMA encourage legislation in Indiana requiring all eldercare applicants have a nationwide background check performed before hiring; and be it further

RESOLVED, that the ISMA encourage the AMA to support federal legislation requiring a nationwide background check on all eldercare applicants before hiring.

RESOLUTION 09-04

NEED FOR ALTERNATIVE COVERED
MEDICATIONS TO BE PROVIDED, UPON
REQUEST, FOR A PRIOR AUTHORIZATION

Introduced by:

Marc B. Willage, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, there are many different forms of not only commercial insurance, but also of Medicaid and "Part D" coverages; and

Whereas, each of the above mentioned entities have differing lists of medications that would be allowed, upon denial of coverage for initially prescribed medication; therefore, be it

RESOLVED, that the ISMA initiate and support legislation requiring insuring entities to list covered medications to choose from, upon denial of coverage for initially prescribed medication requiring prior authorization - for consideration at times when there is no compelling reason to stick with the initially prescribed medication.

RESOLUTION 09-05

MEDICAL MARIJUANA

Introduced by:

Clark Brittain, D.O.

Referred to:

REFERENCE COMMITTEE II

Whereas, one of the primary roles of physicians is to relieve pain and suffering as much as possible; and

Whereas, to achieve this end, physicians have always been willing to use potent, potentially harmful, even potentially lethal drugs (such as morphine); and

Whereas, adverse reactions to drugs such as aspirin and ibuprofen account for 7,600 deaths and 76,000 hospitalizations in the United States, which has not led physicians to call for a ban of these products because their therapeutic benefits outweigh their risks; and

Whereas, in contrast, marijuana has not been shown to cause any deaths and, compared to the medications we use on a daily basis with patients, has almost no adverse side effects; and

Whereas, the medical use of marijuana should be considered entirely separate from the discussion as to its general legalization, just as we have always done with drugs such as morphine; that is, the debate surrounding legalization for general use should not obscure scientific findings regarding legitimate, medically prescribed use; and

Whereas, in 1997, the White House Office of National Drug Control Policy asked the Institute of Medicine (IOM) to review scientific evidence and assess the risks and benefits of marijuana. (They concluded marijuana has therapeutic properties that can treat many illnesses and conditions. They further noted that "...adverse side effects of marijuana use are within the range of effects tolerated for other medications." Some of these uses include treatment for HIV wasting, glaucoma, neurological movement disorders and analgesia, and anti-emetic effect for some cancer patients.); and

Whereas, the national American College of Physicians (ACP) Health and Public Policy Committee has released a 2008 Position Paper, approved by the ACP Board of Regents, supporting exemption from criminal or civil penalties for physicians prescribing and patients using medical marijuana; and

Whereas, we should not ignore an effective and safe therapeutic option for patients because of the social discomfort we feel with its association with illegal street drug use

(any more than we do for many other drugs that we prescribe that also can be abused, such as morphine, codeine, hydrocodone, duragesic and oxycontin); and

Whereas, there are now 13 states in the United States that allow medical marijuana for their residents, and Illinois is also considering a proposal; the Minnesota legislature recently approved legislation that was vetoed by its governor; additionally, Ohio allows for a minor fine for possession of small amounts of marijuana and no incarceration, etc.; therefore, be it

RESOLVED, that the ISMA join the American College of Physicians (ACP) and the Institute of Medicine (IOM) in encouraging legislation that would allow licensed physicians to legally prescribe medical marijuana to patients suffering medical conditions where, in their medical judgment, it is the best therapeutic option for the patient ; and be it further

RESOLVED, that the ISMA encourage legislation that would provide a mechanism for the production and distribution of marijuana for medical purposes, and provide the legal means, such as medical necessity defense, to thwart the federal government from interfering with this effort. This would in no way be supporting its legalization for general use, outside of medical practice.

RESOLUTION 09-06

DIETARY SUPPLEMENTS

Introduced by:

Caitilin Kelly, M.D.; Monroe/Owen County
Medical Society; 2nd District Medical Society;
ACP Indiana Chapter Health and Public Policy
Committee

Referred to:

REFERENCE COMMITTEE II

Whereas, dietary supplements are taken by millions of Americans and represent a \$19 billion a year business; and

Whereas, recent independent lab testing has found that many products often do not contain the stated amount of each ingredient – sometimes having much less, sometimes much more; and

Whereas, having too little (some products did not contain the stated amount of folic acid) or too much (some had dangerous levels of vitamin A) can cause significant harm to unsuspecting consumers; and

Whereas, this testing also has revealed many products to be contaminated by potentially toxic substances including unacceptable levels of lead in children's vitamins, as shown by a recent study; and

Whereas, it should be considered fraud not to have what is stated on the label; and

Whereas, consumers should have the right to expect uncontaminated supplements just as they expect it with other food products; therefore, be it

RESOLVED, that the ISMA work with legislators to encourage 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.

RESOLUTION 09-07

POST-SURGICAL CARE RESPONSIBILITIES

Introduced by:

ISMA Board of Trustees, Brent Mohr, M.D., chair

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 08-47 "ASSESSMENT AND TRACKING OF NON-HOSPITAL CREDENTIALLED PHYSICIANS" stated as follows:

RESOLVED, that the ISMA begin a dialogue with the Indiana State Department of Health to address by rule, the issue of hospital quality assurance committees reporting non-privileged physicians that are believed to have demonstrated a sub-standard level of care to the Medical Licensing Board of Indiana when the physician's patient has presented to that hospital for treatment of associated complications. This is to assure that the conduct and complications are addressed either at the local hospital Quality Assurance Committee level, or reported to the Medical Licensing Board of Indiana.

and

Whereas, Resolution 08-47 was Referred to the Board of Trustees for Action; and

Whereas, the Board of Trustees referred Resolution 08-47 to the ISMA Task Force on Peer Review; and

Whereas, the Task Force on Peer Review considered extensive amounts of information, including the following:

- Current Indiana law requires a physician who becomes aware of illegal, unlawful, incompetent or fraudulent conduct in the practice of medicine to report the conduct to a peer review body. The law also permits a physician to make a report to the Medical Licensing Board. Physicians are generally reluctant to make such reports.
- Hospitals do not appear to be reporting such illegal, unlawful or incompetent conduct.
- This issue was presented to the Medical Licensing Board in February 2009, and it was learned that a complaint has reportedly been filed with the Office of the Attorney General against a physician for alleged failure to provide sufficient follow-up care, but the Office of Attorney General has not filed charges and the physician has not been called before the Medical Licensing Board.

- The Medical Licensing Board is aware that the ISMA is studying this issue and has asked to be notified of ISMA's actions.
- The Medical Licensing Board adopted Office-Based Surgery rules in 2008 that require physicians who perform in-office anesthesia to have privileges at a local hospital or Ambulatory Surgery Center, or for the office-based setting to have peer review privileging processes in place. The rule also addresses post-operative care and requires a physician to have admitting privileges at a nearby hospital or to make transfer arrangements with another privileged physician or hospital.

and

Whereas, the Task Force on Peer Review reached the following conclusions:

- There are many concerns with requiring hospital credentialing, including hospital obligations, conflicts of interest, and hospitals exercising oversight of unaffiliated surgery centers.
- These issues should be regulated by the Medical Licensing Board and not the Indiana State Department of Health or county health departments.

and

Whereas, the Task Force on Peer Review recommended that the Board of Trustees recommend that the Medical Licensing Board promulgate a rule on post-surgical care responsibility; and

Whereas, the Board of Trustees accepted the Task Force on Peer Review's recommendations; therefore, be it

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 a surgical patient of the physician 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 09-08

MALPRACTICE INSURANCE ASSISTANCE

Introduced by:

Betty J. Campbell, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, there are times when significant natural, inflicted or medical disasters occur involving members of the medical profession; and

Whereas, there are times when some disasters have a significant impact upon the financial ability of the physician to maintain an office setting or practice; and

Whereas, a significant portion of the financial overhead of medical practice includes malpractice insurance; therefore, be it

RESOLVED, that 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 09-09

DUES WAIVERS

Introduced by:

Betty J. Campbell, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, under certain circumstances the ISMA member district or county medical societies may want to recommend waiving membership dues for a specific member or members for a specified term; and

Whereas, specific reasons or categories of reasons should be delineated for such recommendations (i.e., nationally declared disaster area such as flood, tornado, hurricane or devastating fire; personal disaster of similar nature; overwhelming medical illness; or other personal financial disaster); therefore, be it

RESOLVED, the ISMA should act on dues waiver requests as approved and forwarded by the initiating county by waiving member dues for a period not to exceed two years with the option for renewal at the end of that time. Member so identified is to remain in active status as long as member continues to practice in the area.

RESOLUTION 09-10

INDIANA DEPARTMENT OF INSURANCE
PROVIDER COMPLAINTS

Introduced by:

David Welsh, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, the Indiana Department of Insurance (IDOI) is the state agency charged with oversight of health insurance companies; and

Whereas, the IDOI is charged with issuing an annual index totaling complaints filed against all health insurance companies; and

Whereas, Anthem routinely tells the IDOI not to include ERISA complaints in its annual complaint index and IDOI does not include them; and

Whereas, the IDOI has complaint forms on its Web site that consumers and health care providers, including physicians, can use to file complaints against health insurance companies; and

Whereas, the patient complaint form can be filed electronically, but the provider complaint form must be filed by fax or postal mail; and

Whereas, the IDOI unilaterally revised its provider complaint form in approximately late April 2009 to prohibit physicians from filing complaints valued at less than \$250 and prohibiting hospitals from filing complaints worth less than \$5,000; and

Whereas, the ISMA has approached IDOI about the complaint form change and IDOI states that it is not statutorily required to accept provider complaints and has to-date refused ISMA's request to remove the dollar thresholds; and

Whereas, at least one physician's office has already notified the ISMA that IDOI refused its complaint because it did not meet the dollar threshold; therefore, be it

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; and be it further

RESOLVED, that the ISMA seek to amend current Indiana law in 2010 to require the Indiana Department of Insurance to include all ERISA complaints in each health insurance company's annual complaint index.

RESOLUTION 09-11

SMOKE-FREE ISMA

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, the ISMA has banned smoking from ISMA events since 1979 and resolution 99-41 maintained such policy; therefore, be it

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 the association's facilities; and be it further

RESOLVED, that the ISMA attempt to hold all business and educational events in totally non-smoking surroundings.

RESOLUTION 09-12

CELL PHONES AND DRIVING (A PRE-DEATH EXPERIENCE)

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, recent reports and studies indicate that:

1. Drivers using cell phones are four times as likely to cause a crash
2. Drivers using cell phones are as likely to crash as if driving with a 0.08 percent blood alcohol concentration
3. Hands-free devices do not eliminate risks and may even worsen risks by suggesting such behavior as safe
4. Cell phone distractions cause 2,600 U.S. traffic deaths each year with 330,000 crashes that result in injuries
5. Drivers overestimate their own ability to safely multi-task
6. Functional MRI studies show clearly that when drivers concentrate listening on a phone, the part of the brain that controls vision becomes less effective, and vice versa; therefore, be it

RESOLVED, that the ISMA seek and support state and federal legislation, policy, rules and regulations to prohibit the use of wireless communication devices while driving, except in emergency situations.

RESOLUTION 09-13

TOBACCO SETTLEMENT

Introduced by:

Dick Huber, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, resolution 99-31A resulted in the ISMA adopting policy addressing monies from the tobacco settlement; therefore, be it

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, 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.

RESOLUTION 09-14 RESCISSION

Introduced by: Caitilin Kelly, M.D.; the Indiana ACP Health and Public Policy Committee; ACP Governor's Council; Michael Sha, M.D.; Deepak Azad, M.D.; Lois Lambrecht, M.D.; Robert Lubitz, M.D.; and Linda Abels, M.D.

Referred to: REFERENCE COMMITTEE II

Whereas, the executives of three of the nation's largest health insurers have told federal lawmakers that they will continue the act of retroactively canceling insurance, called "rescission," despite requests from both Democrat and Republican legislators to limit this practice to only policyholders who intentionally lie or commit fraud to obtain coverage; and

Whereas, these same three insurers have cancelled coverage of more than 20,000 people, allowing the insurers to avoid paying more than \$300 million in medical claims over a five-year period; and

Whereas, policy holders with breast cancer, lymphoma and more than 1,000 other conditions were targeted for rescission and insurers' employees were praised in performance reviews for terminating the policies of customers with expensive illness; and

Whereas, a typical example of this practice is a woman diagnosed with breast cancer who inadvertently omitted a visit to the dermatologist for acne decades earlier, and on that basis had her coverage dropped, just when it was most needed; and

Whereas, in some cases patients had not even been informed of specific minor abnormalities on scans or blood tests found in their records; and

Whereas, this practice is clearly unethical; and

Whereas, this practice leads to large numbers of medical bankruptcy cases, the leading cause of bankruptcy in the U.S.; therefore, be it

RESOLVED, that the ISMA and the ACP work at the state and national levels to pass legislation requiring health insurers to limit the practice of rescission only to policyholders who intentionally lie or commit fraud to obtain coverage.

RESOLUTION 09-15 LABELING OF GENETICALLY MODIFIED FOODS

Introduced by: Caitilin Kelly, M.D.; the Indiana ACP Health and Public Policy Committee; ACP Governor's Council; Michael Sha, M.D.; Deepak Azad, M.D.; Lois Lambrecht, M.D.; Robert Lubitz, M.D.; and Linda Abels, M.D.

Referred to: REFERENCE COMMITTEE IV

Whereas, an estimated 70-75 percent of processed foods on supermarket shelves contain genetically engineered ingredients; and

Whereas, up to 45 percent of U.S. corn and up to 86 percent of U.S soybeans are genetically modified; and

Whereas, genetically engineered foods may pose potential serious risks to humans, including higher risks of toxicity, allergenicity, antibiotic resistance, immune-suppression and cancer; and

Whereas, eight federal agencies attempt to regulate biotechnology using 12 different statutes or laws written long before the advent of genetically engineered food, animals and insects; and

Whereas, the current argument opposing the labeling of genetically modified food is that much of the public would be unnecessarily frightened and reluctant to buy foods thus identified; and

Whereas, this argument should nevertheless not override the public's right to be informed of the nature and source of their food, and should instead motivate the companies and industries producing and utilizing genetically modified food to fund and perform the needed studies to prove its safety and subsequently inform and educate the public; therefore, be it

RESOLVED, that the ISMA seek legislation requiring that any foods containing genetically engineered ingredients be clearly labeled.

RESOLUTION 09-16

CHOICE REGARDING HEALTH CARE
INSURANCE/PROVIDER PRACTICES

Introduced by: Steven Rupert, D.O., and Stacie Wenk, D.O.

Referred to: REFERENCE COMMITTEE I

Whereas, the 10th amendment protects the states and its people against limiting choices not expressly described in the constitution; and

Whereas, health care is not expressly described in the constitution, and choice and liberty is a fundamental freedom and expectation in the U.S.; therefore, be it

RESOLVED, that the ISMA House of Delegates (HOD), from all the districts of Indiana, vote to either accept or reject the idea of national health care as accepted by the AMA; and be it further

RESOLVED, that the ISMA send a letter based upon the HOD vote of acceptance or rejection of national health care legislation to the AMA and to all state and federal senators and representatives; and be it further

RESOLVED, that the ISMA design a state-run health care program, or a publicly owned health care service organization, independent of any federal program based on a medical cooperative, giving low cost medical services back to those who are members/owners; this would include diagnostic radiology, laboratory services and pharmacy; since all medical equipment will be owned prior to installation, the only cost would be utilities, office and technicians' salaries, and medical supplies; the majority of the cost would be paid for by the yearly membership fee and minimal service charges for each service rendered, and there will be no profits designed for this not-for-profit organization; and be it further

RESOLVED, that the ISMA seek legislation that would provide support for state or publicly owned health care service organizations; and be it further

RESOLVED, that the ISMA seek legislation allowing doctors to accept Indiana Medicaid residents at the present reimbursement rates and deduct the loss of income on their state taxes with the write-off at 150 percent of the Medicare price, based on 2005 Medicare rates minus the 2009 Medicaid rate; and be it further

RESOLVED, that the ISMA seek legislation protecting the citizens of Indiana that would allow them choice between a government-run health care system versus a private-run health care system, without incurring a penalty or a tax.

RESOLUTION 09-17

THE PHYSICIAN'S OBLIGATION TO IDENTIFY AND
TREAT PRENATAL AND PERINATAL ADDICTION

Introduced By:

Randall Stevens, M.D., and James Norton, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, prenatal alcohol exposure is associated with significant maternal and fetal health risks including spontaneous abortion, prenatal and postnatal growth restriction birth defects, and neurodevelopment deficits, including fetal alcohol syndrome - the most common cause of mental retardation;¹ and

Whereas, smoking during pregnancy increases the likelihood of placenta previa, abruption, premature rupture of membranes, preterm delivery, fetal growth restriction, low birth weight, as well as increasing incidence of orofacial cleft defects and sudden infant death syndrome after birth;² and

Whereas, illicit drug use during pregnancy, especially cocaine use, has been linked to increased risk of low birth weight, prematurity, perinatal death, abruptio placenta and small or gestational age births;³ and

Whereas, the 2006 *National Survey on Drug Use and Health* found that 11.8 percent of pregnant women reported current alcohol use and 2.9 percent reported binge drinking (greater than 5 drinks on the same occasion), 16.5 percent of pregnant woman reported tobacco use during pregnancy, and 4 percent of women reported using illicit drugs during pregnancy;⁴ and

Whereas, a variety of screening tools have been introduced to properly screen and identify pregnant women using alcohol, tobacco and illicit drugs, including the 5 A's of tobacco, TACE for alcohol, and FRAMES for other drug use;⁵ and

Whereas, the American College of Obstetricians and Gynecologists endorses universal screening as an ethical obligation;⁶ and

Whereas, one study showed that by merely identifying the pregnant substance user and the particular substance(s) used, 54% of women cleaned up after brief physician advice and a urine drug screen at each prenatal visit;⁷ and

Whereas, in one treatment facility from 2002-2008, detection and simple intervention resulted in 274/323 (84.8%) substance-free births, with a pre-term rate of 22.2% (pre-term delivery rate for all patients in this hospital is 19.6%);⁸ and

Whereas, in that same facility, of the patients who were identified as positive with a urine drug screen who did not return for prenatal care but who did show up for delivery, 26/49 (53%) were substance-free births, indicating that the process of detection is, in fact, an intervention in and of itself;⁹ and

Whereas, ISMA historically has expressed concern for a healthy intrauterine environment for the prenatal period; and

Whereas, ISMA supports initiatives to help those who are addicted to drugs and ask for help, and supports government initiatives to implement substance abuse programs that are appropriately designed and monitored for quality, cost effectiveness, and reduced recidivism; therefore, be it

RESOLVED, that the ISMA, through its communication vehicles, encourage all physicians to increase their knowledge regarding the effects of drug and alcohol abuse during pregnancy and communicate that information to women of reproductive age pre-conception; and

RESOLVED, that the ISMA encourage Indiana physicians to routinely inquire about alcohol, tobacco and drug use in the course of providing prenatal care; and

RESOLVED, that the ISMA encourage Indiana physicians to identify alcohol, tobacco and drug use in their pregnant patients and provide these women with treatment options best suited to their needs; and

RESOLVED, that the ISMA implore Indiana hospitals to study the prevalence and effects of implementing a simple alcohol, tobacco and drug screening process during patient pregnancy.

1. R.L. Floyd, *et al.*, **The clinical content of preconception care: alcohol, tobacco, and illicit drug exposures** *American Journal of Obstetrics & Gynecology* December 2008 (Vol. 199, Issue 6, Pages S333-S339)

²Id.

3 Id.

4 2006 *National Survey on Drug Use and Health*, <http://www.oas.samhsa.gov/nsduh/2k6nsduh/2k6results.pdf> (Last accessed 03/04/2009)

⁵ *American Journal of Obstetrics & Gynecology*, December 2008 (Vol. 199, Issue 6, Pages S333-S339)

6. American College of Obstetricians and Gynecologists, **At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice**, ACOG Committee Opinion No. 422, Dec. 2008.

7. I.J. Chasnoff, *et al.* **The 4P's Plus Screen for Substance Use in Pregnancy: Clinical Application and Outcomes.** *Journal of Perinatology* (2005)25, 368-374.

⁸ James. J. Nocon, M.D., J.D., Director Prenatal Substance Use Clinic, Wishard Memorial Hospital, 1001 West 10th Street, F5102, Indianapolis, IN 46202

9. Id

RESOLUTION 09-18

SUPPORT OF GAY MARRIAGE

Introduced by:

William Buffie, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, we live in a multicultural society wherein *all* people are created equal in the eyes of God and our constitution; and

Whereas, the principle of separation of church and state is essential to uphold in our diverse society; and

Whereas, to be consistent with the above, it is necessary that personal interpretation of one's own individual scripture should not be a basis for deciding whether homosexuality is determined by orientation or choice; and

Whereas, the medical literature overwhelmingly supports the opinion that homosexuality is a function of biological orientation rather than choice; and

Whereas, the ISMA is a body that is to be guided in its decision-making by science, reason and public policy standards that promote the health and well being of *all* Indiana citizens;

Whereas, the health benefits of a *legally sanctioned* marital relationship, regardless of the sexual orientation of the partners, are acknowledged by numerous medical associations and research forums; therefore, be it

RESOLVED, that the ISMA publically acknowledge the health benefits conferred upon our LGBTQ (Lesbian, Gay, Bisexual, Transgendered, Questioning) community that might be offered through the legal sanctioning of gay marriage.

RESOLUTION 09-19

SUPPORTING AWARENESS OF STRESS DISORDERS IN
MILITARY MEMBERS AND THEIR FAMILIES

Introduced by: William W. Pond, M.D.

Referred to: REFERENCE COMMITTEE IV

Whereas, AMA policy (D-510.996 Military Care in the Public and Private Sector) states:

“Our AMA will use its influence to expedite quality medical care, including mental health care, for all military personnel and their families by developing a national initiative and strategies to utilize civilian health care resources to complement the federal health care systems. (Res. 444, A-07); and

Whereas, a 2008 ISMA resolution supporting awareness of stress disorders in military members and their families complements and supports the AMA policy and was met with significant success in Indiana; and

Whereas, with the backing and encouragement of the ISMA, the 2009 Indiana General Assembly passed Concurrent Resolution 69 that :

“supports compassionate treatment and efforts to raise awareness of PTSD and other associated psychiatric disorders related to the unique stresses of members of the armed forces and their families,

“encourages physicians throughout Indiana to query patients and their families regarding stresses related to military deployment, and

“encourages the Indiana State Medical Association to promote awareness and disseminate information regarding resources that are available for the assistance of members of the armed forces and their families.”

and

Whereas, the 2009 ISMA Alliance has adopted as its annual focus project “Treat the Troops, Mental Health Matters,” to address PTSD awareness as it impacts military members and their families; and

Whereas, military members have been, are and will continue to be deployed overseas, often to hostile environments; and

Whereas, the stresses of combat may cause Post Traumatic Stress Disorder (PTSD) in as many as 1:8 deployed soldiers; and

Whereas, the stresses of deployment and PTSD also affect family members; and

Whereas, treatment of military family members is primarily accomplished by nonmilitary physicians throughout the U.S.; and

Whereas, presenting medical complaints to the primary care physician may be a manifestation of, or exacerbated by, stress disorders; and

Whereas, early compassionate treatment of patients and their families is more likely to lead to successful resolution of stress disorders, thereby decreasing the likelihood of chronic symptoms or even permanent disability; therefore, be it

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 develop 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, developing a screening tool, educating physicians, disseminating information and expediting treatment for military members and their families affected by stress disorders.

RESOLUTION 09-20

OPPOSITION TO INTELLIGENDER

Introduced by:

Caitilin Kelly, M.D., chair of the Ind. ACP Health and Public Policy Committee, Deepak Azad, M.D., Robert Lubitz, M.D., Michael Sha, M.D., and Lois Lambrecht, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, sex discrimination by gender selection has been widely practiced in many countries, including India and China; and

Whereas, the manufacturer Intelligender retails in the U.S. and Canada a \$39.95 home unit that is about 80 percent accurate in determining the sex of a fetus at 10 weeks, and is marketed as “a fun way to discover more about your baby and share the news of pink or blue as early as possible”; and

Whereas, Intelligender has sold 50,000 units online since placing it on the market in November 2006; and

Whereas, medical ethicists have raised concerns that the significant risks of misuse of this product far outweigh any benefits; and

Whereas, the co-founder of Intelligender has stated that the company refuses to sell its product in India or China because “They have different cultural beliefs than we do”; and

Whereas, such a statement fails to acknowledge that the U.S. is a multicultural society made up of individuals with many diverse beliefs and it is naive to assume the same risks of misuse for gender selection, a form of sex discrimination, do not exist here; therefore, be it

RESOLVED, that the ISMA encourage removal from the market of the gender-prediction test made by Intelligender.

RESOLUTION 09-21

SUSPENSION OF MEDICAID PRIVILEGES FOR
POSITIVE DRUG TEST

Introduced by:

P.K. Samaddar, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, patients receive Medicaid benefits due to their financial inability to afford health insurance and/or pay medical bills; and

Whereas, the Medicaid system is funded by Indiana tax payer dollars; and

Whereas, at times, Medicaid patients abuse prescription and/or illegal drugs and devote their financial resources to this abuse; therefore be it

RESOLVED, that ISMA support the suspension of Medicaid privileges of patients who test positive for illegal and/or prescription drugs not prescribed for them.

RESOLUTION 09-22

CIVIL LEGAL SYSTEM

Introduced by:

P.K. Samaddar, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, the U.S. legal system is based in part upon that of England; and

Whereas, substantial differences have evolved over the past two centuries in the procedural methods regarding the manner in which civil tort cases are adjudicated; and

Whereas, the current English procedural system requires the unsuccessful plaintiff to compensate the defendant for both pain and suffering and attorney fees; and

Whereas, frivolous lawsuits against a physician can cause severe financial, emotional and personal difficulties and can potentially have a lasting negative impact on a physician's private practice; and

Whereas, putting the financial burden on the losing party in a malpractice lawsuit might decrease the likelihood of such frivolous lawsuits; therefore, be it

RESOLVED, that the ISMA support a change in the civil legal system that would force the plaintiff patient in a malpractice lawsuit to pay the defendant physician compensatory and punitive damages if the plaintiff patient loses at court.

RESOLUTION 09-23

ATTORNEY GENERAL DEFENSE OF PHYSICIANS
NAMED IN CIVIL RIGHTS SUITS BY PRISONERS

Introduced by:

Vidya Kora, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, physicians treating prisoners are subject to being named by prisoners in medical malpractice and civil rights discrimination lawsuits; and

Whereas, medical malpractice insurance generally does not cover civil rights discrimination lawsuits or medical malpractice lawsuits arising from jail services; and

Whereas, prisoners are considered to be more litigious, can have difficult personalities, and often have mental health or addiction issues that are difficult to treat; and

Whereas, physicians should not be deterred from treating prisoners, regardless of the setting; and

Whereas, physicians working in hospital emergency rooms or fulfilling emergency on-call obligations cannot refuse to treat a patient; and

Whereas, Indiana law provides immunity for employees and contractors of the state in civil suits in certain circumstances, but not for providing medical care; and

Whereas, Indiana law provides that the Office of the Indiana Attorney General will defend employees and contractors of the state in civil rights cases in certain circumstances; and

Whereas, a physician who is an employee or contractor of a jail could request the defense of the Indiana Attorney General in civil rights cases brought by prisoners, but a physician treating a prisoner in a hospital setting cannot; therefore be it

RESOLVED, that the ISMA seek legislation that will provide physicians who are employees or contractors of the state immunity in all civil suits brought by prisoners, including medical malpractice; and be it further

RESOLVED, that the ISMA seek legislation requiring the Office of the Indiana Attorney General to defend civil rights discrimination lawsuits brought against all physicians treating prisoners of the state inside a hospital.

RESOLUTION 09-24

BODY MODIFICATION

Introduced by:

Debra Mc Mahan, M.D., and the Fort Wayne Medical Society

Referred to:

REFERENCE COMMITTEE IV

Whereas, body modification practice includes the following:

- Suspension - The act of suspending a human body from hooks (typically deep-sea hooks) that have been put through body piercings on various parts of the body, including the torso or extremities. These piercings are temporary and are performed just prior to the actual suspension. The client is then raised off the ground with a block and tackle-like machine via ropes attached to the hooks. Risks include infection, bleeding, tearing of the skin, asphyxia or aspiration.
- Tongue splitting - The tongue is cut centrally from its tip part of the way towards its base with a scalpel. The round nature is achieved by placing sutures in the upper and lower part of the cutting area.
- Microdermal implants - A dermal punch is used to remove a circular area of tissue. Implants are then anchored into the muscle. Interchangeable jewelry is screwed into the threaded hole in the anchor.
- Subdermal implants - These are buried in the skin and referred to as similar to the medical procedure of installing a pacemaker.
- Transdermal implants - These are placed under the skin, but also protrude out of it. This is done through a process known as 'dermal punching.' The implant is placed in between the layers of skin. Once the implant is placed, the part that will protrude out is exposed using a dermal punch.
- Scalpelling - Scalpel is used to produce holes of large diameter that provide quicker and greater control over holes than skin stretching.
- Scarification - Scars are formed by cutting or branding the skin. A scalpel is used to cut the skin and then ink may be rubbed onto the fresh cut. Alternatively, foreign bodies (e.g., cremation ashes) may be used to "pack" the wound to create massive keloids.
- Skinning - A form of scarification in which a design is stenciled onto the skin. The design is outlined as a single cutting scarification and then the artist begins removing skin slices with the help of a scalpel and a Kocher forceps or dissection clamp.
- Nullification (or amputation) -This involves surgical removal of all or part of a limb, most commonly this involves castration, amputation of fingers or toes, removal of nipples, or removal of full limbs.

And,

Whereas, according to IC 25-22.5-1-1.1 (a)(1), the practice of medicine is defined as:

(a) "Practice of medicine or osteopathic medicine" means any one (1) or a combination of the following:

(1) Holding oneself out to the public as being engaged in:

(A) The diagnosis, treatment, correction, or prevention of any disease, ailment, defect, injury, infirmity, deformity, pain, or other condition of human beings;

(B) The suggestion, recommendation, or prescription or administration of any form of treatment, without limitation;

(C) *The performing of any kind of surgical operation upon a human being, including tattooing, except for tattooing (as defined in IC 35-42-2-7), in which human tissue is cut, burned, or vaporized by the use of any mechanical means, laser, or ionizing radiation, or the penetration of the skin or body orifice by any means, for the intended palliation, relief, or cure; ...*

and,

Whereas, the above procedures require the use of medical equipment, including but not limited to scalpel and forceps; and

Whereas, the above procedures require an extensive knowledge of human anatomy, physiology and surgical practice; therefore, be it

RESOLVED, that the ISMA seek legislation that would add the term "body modification" to the definition of the practice of medicine as defined under IC 25-22.5-1-1.1(a)(1).

RESOLUTION 09-25 NEWBORN AUTO ASSIGNMENT AND RETRO-ACTIVE
ASSIGNMENT TO MEDICAID MANAGED CARE
ORGANIZATIONS

Introduced by: Teresa Lovins, M.D., Indiana Academy of Family Physicians
and the Indiana Chapter of the American Academy of
Pediatrics

Referred to: REFERENCE COMMITTEE III

Whereas, the state of Indiana, through the Division of Family Services, has divided the Medicaid services provided to state residents into several managed care organizations (MCO) programs; and

Whereas, patients can designate their preference for a particular MCO plan coverage for their family based upon the physician or services they desire; and

Whereas, there is a precedent that newborn patients are automatically enrolled in the mother's Medicaid MCO when their mother have been covered under the Medicaid MCO plans during pregnancy; and

Whereas, it takes some time for patients' parents to actually enroll infants with their Medicaid MCOs of choice; and

Whereas, the MCO assignment is retroactive for services provided to newborns from birth; and

Whereas, newborns have already received services from Medicaid providers prior to those retroactive assignments; and

Whereas, the retroactive auto-assignment does not always attach the infants to the same MCOs as the physician of record or parental choice; and

Whereas, the auto-assignment to an Medicaid managed care organization (MCO) can prevent continuity of care for newborns; and

Whereas, auto-assignment policies/procedures can disrupt the establishment of the medical home and potentially jeopardize the early identification of preventable problems in the newborn period; and

Whereas, the auto-assignment can prevent the provider of services from receiving payment at their Medicaid managed care organization (MCO) contracted rates; therefore be it

RESOLVED, that the ISMA through legislation, regulation or agreements work to stop the automatic assigning of MCO coverage for newborn infants in Indiana; and be it further

RESOLVED, that the ISMA through legislation, regulation or agreements work to ensure that MCO coverage for newborn infants is retroactive to birth; and be it further

RESOLVED, that the ISMA through legislation, regulation or agreements work to ensure MCO 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 09-26

SIMPLE AND UNIFORM PRIOR AUTHORIZATION
FORMS

Introduced by:

Teresa Lovins, M.D, and the Indiana Academy of
Family Physicians

Referred to:

REFERENCE COMMITTEE III

Whereas, recent studies have found that time spent on paperwork costs physicians several hours each week that distract from patient care; and

Whereas, other studies have shown that as much as 20 percent of health care dollars are spent in managing insurance company-driven paperwork; and

Whereas, the same data show that primary care physicians are disproportionately burdened with this work; and

Whereas, most insurers – both public and private – demand similar information; and

Whereas, non-standardized forms add to the delay in collecting and submitting information to payers; therefore be it

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 process for physicians to pursue appropriate exceptions for individual patients.

RESOLUTION 09-27

LABORATORY TESTING

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 81-24 Clinical Laboratory Tests Referred Out of State of Indiana was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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 physician and patients in Indiana and endeavor to fulfill these needs.

RESOLUTION 09-28

HOSPITAL DELIVERIES

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 81-27 ISMA Opposition to Concept of Home Deliveries was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-29

OPPOSITION TO THIRD-PARTY PAYMENT

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 82-6 Rescinding Resolution 62-26 was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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 09-30

LIMITING PHYSICIAN FREE CHOICE

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 84-24 Closing of Staffs and Services was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-31

MOTORCYCLE HELMETS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 85-17 Motorcycle Helmets was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; and

Whereas, Indiana law only requires motorcycle drivers to wear protective headgear when they have a learner's permit or a temporary learner's permit; therefore, be it

RESOLVED, that the ISMA support legislation to require protective headgear to be worn by all drivers and passengers of motorcycles at all times.

RESOLUTION 09-32

FINANCIAL INCENTIVES

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 86-7 Quality Medical Care was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that physicians of Indiana will not compromise the quality of medical care because of financial incentives.

RESOLUTION 09-33

PROHIBITING UNLICENSED MID-WIFERY

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 86-36 Lay Midwives was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that the ISMA recommend enforcement of existing laws that prohibit midwifery by unlicensed individuals.

RESOLUTION 09-34

NOTIFICATION OF PROFESSIONAL LICENSING
AGENCY ACTIONS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 87-16 Notification of Medical Societies and Hospitals by the Medical Licensing Board of Indiana (Health Professions Service Bureau) was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; and

Whereas, the Health Professions Bureau was renamed the Professional Licensing Agency; and

Whereas, the Professional Licensing Agency appears to be doing a better job of promptly notifying the appropriate entities of license restrictions; therefore, be it

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 09-35

INSURANCE REIMBURSEMENT

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 87-20 Penalties for Fiscal Intermediaries Who Do Not Reimburse Patients Promptly was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that ISMA seek imposition of federal and/or state sanctions on the insurance carriers that do not reimburse patients promptly or correctly.

RESOLUTION 09-36

APPROPRIATE STATEMENTS OF CARE

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 88-6A Communication/Methods by Insurers was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-37

REQUIRING INSURERS TO CLEARLY DISCLOSE
LIMITATIONS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 88-28 Truth in Insurance Bill was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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 09-38

GME FUNDING

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 89-13 Additional Funding for Graduate Medical Education was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that the ISMA support the concept and help seek additional funding for Graduate Medical Education from the Indiana General Assembly.

RESOLUTION 09-39

MEDICAL CAREERS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 89-19 Medical Career Development Programs was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-40

PENALTIES FOR CODING ERRORS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 89-4 Opposition to Mandatory Coding was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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 09-41

COMPACT OF CONDUCT

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 86-6 Medical-Legal Compact of Conduct of the Indiana State Bar Association and Indiana State Medical Association was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that the ISMA approve the Medical-Legal Compact of Conduct of the Indiana State Bar Association and the Indiana State Medical Association.

RESOLUTION 09-42

OPPOSE MEDICARE CUTS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, Resolution 89-50 Medicare Appropriations was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that the ISMA oppose cuts by Congress to Medicare appropriations.

RESOLUTION 09-43

PROVIDING INFORMATION FOR SCHOOL
HEALTH POLICIES AND CRITERIA

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 89-28A School Health Clinics was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that the ISMA, in cooperation with interested governmental offices and organizations such as the State Department of Education, the 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.

RESOLUTION 09-44

UNREASONABLE AND UNNECESSARY SERVICES

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 89-53 "Unreasonable and Unnecessary" Terminology for Services was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-45

TESTING FOR HIV

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 89-42 Testing for Human Immunodeficiency Virus (HIV) was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-46

GENERIC SUBSTITUTION BY PHARMACIST

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, Resolution 76-1 Generic Substitution of a Prescribed Drug was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; and

Whereas, current law allows a pharmacist to substitute generic prescriptions under two circumstances:

1. If the patient is covered by a government health program (Medicaid, Children's Health Insurance Program and Medicare), the pharmacist **must** substitute generic medication when it is less expensive unless the words "Brand Medically Necessary" are written in the practitioner's own writing or included with an electronically transmitted prescription;
2. If the patient is not covered by a government health program, the pharmacist may substitute generic medication if the physician signs the "May substitute" line of the paper prescription or indicates "may substitute" on an electronically transmitted prescription;

therefore, be it

RESOLVED, that the ISMA oppose generic substitution for a prescribed drug done at the discretion of a pharmacist.

RESOLUTION 09-47

POSTOPERATIVE CARE

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 86-47 Postoperative Care of Surgical Patients was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-48

PHYSICIAN HEALTH OFFICERS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 86-48 Physician Health Officers was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-49

LIMIT RESIDENT WORK HOURS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 89-44 Resident Work Hours was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that the ISMA support, in principle, the need to limit resident work hours and support the guidelines of the Accreditation Council for Graduate Medical Education for resolution of the issue.

RESOLUTION 09-50

NON-PHYSICIAN DIAGNOSIS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, the Resolution entitled Non-Physician Diagnosis from the 1973 House of Delegates was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-51

DRUG-FREE INDIANA ENDORSEMENT

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 89-18 Drug-Free Indiana was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that ISMA endorse the concept of a drug-free Indiana and lend its support and expertise to attain this goal when asked to participate.

RESOLUTION 09-52

DISPENSING MEDICATIONS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, Resolution 87-18 Dispensing Medications from the Office was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-53

ANABOLIC STEROIDS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 86-27 Anabolic Steroids was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

RESOLVED, that the ISMA completely and officially oppose the use of anabolic steroids as a method of enhancing athletic performance at all levels in sports.

RESOLUTION 09-54

STATE FUNDS FOR LOCAL HEALTH
DEPARTMENTS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 99-06 State Funds for Local Health Departments supported adequate funding for county health departments from July 1, 2001, to June 30, 2003; and

Whereas, the ISMA continues to support the need for adequate funding for county health departments; and

Whereas, Resolution 99-06 is set to expire in 2009; therefore, be it

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 health 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.

RESOLUTION 09-55

DOCTORS' UNION

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 99-23A Doctors' Union is set to expire in 2009; therefore, be it

RESOLVED, that the ISMA work to educate members concerning a physician negotiating organization and solicit members' input concerning such an organization.

RESOLUTION 09-56

ORGAN DONATION

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE IV

Whereas, Resolution 99-24 Organ Donation is set to expire in 2009; therefore, be it

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.

RESOLUTION 09-57

COLLECTIVE BARGAINING

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 99-29A Collective Bargaining is set to expire in 2009; therefore, be it

RESOLVED, that the ISMA study the voluntary, patient-oriented provisions of collective bargaining based on the AMA model legislation for collective bargaining.

RESOLUTION 09-58

RESTRICTIVE COVENANTS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 99-33 ISMA Policy on Restrictive Covenants encouraged the ISMA to revise its policy on restrictive covenants to match the AMA's policy; and

Whereas, the ISMA has revised its policy on restrictive covenants to match the AMA, as follows:

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.

and

Whereas, Resolution 99-33 is set to expire in 2009; therefore, be it

RESOLVED, that the ISMA continue to endorse the AMA's policy on restrictive covenants.

RESOLUTION 09-59

USE OF TERM "PROVIDER"

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 99-40 Use of Term "Provider" is set to expire in 2009; therefore, be it

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.

RESOLUTION 09-60

PRESCRIPTION MEDICATION FOR INDIGENT
CARE

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE II

Whereas, Resolution 99-51 Prescription Medication for Indigent Care is set to expire in 2009; therefore, be it

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.

RESOLUTION 09-61

MALPRACTICE COSTS FOR CLINIC WORKERS

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 99-52 Malpractice Costs for Clinic Workers is set to expire in 2009;
and

Whereas, Indiana law provides malpractice immunity for doctors providing free,
uncompensated care at health care clinics, but such law does not include compensated
employees of such clinics; therefore, be it

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 09-62

ADJUSTMENT OF MEDICAID REIMBURSEMENT
RATES

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE III

Whereas, Resolution 99-56 Adjustment of Medicaid Reimbursement Rates is set to expire in 2009; therefore, be it

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 the rates of neighboring states, the national average and Medicare rates in order to improve access to care for the growing number of Medicaid patients in our state.

RESOLUTION 09-63

UNIFORM RATES FOR LIABILITY INSURANCE

Introduced by:

David Welsh, M.D., and Fred Ridge, M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, Resolution 86-32 Uniform Rates for Liability Insurance was readopted as Resolution 99-41 and Resolution 99-41 will expire in 2009; therefore, be it

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.

RESOLUTION 09-64

STUDY THE COST OF ISMA ADMINISTRATIVE
SERVICES FOR SPECIALTY SOCIETIES

Introduced by:

Michael Sha, M.D., Indiana Chapter of ACP and
Indiana Radiology Society

Referred to:

REFERENCE COMMITTEE I

Whereas, the strength of the House of Medicine in Indiana rests on the strength of the Indiana State Medical Association and specialty societies with which the ISMA frequently collaborates; and

Whereas, every physician in practice has both a geographic and specialty designation; and

Whereas, several specialty societies including the Indiana Chapter of the American College of Surgeons, the Indiana Chapter of the American Academy of Pediatrics, the Indiana Chapter of the American College of Physicians, and the ISMA Alliance currently contract for administrative services from the ISMA; and

Whereas, the House of Medicine in Indiana can be strengthened through fostering increased interaction between the ISMA and specialty societies, and one strong means of fostering the strength specialty societies is through the administrative support that the ISMA can offer; and

Whereas, these administrative services are quite costly and outside the price range for many smaller societies; therefore, be it

RESOLVED, that the ISMA Board of Trustees study whether a modest subsidy of the cost of administrative services provided to specialty societies and the ISMA Alliance can foster (1) these organizations' strength and (2) greater participation by smaller societies for which the cost of ISMA-furnished services are currently too prohibitive.

RESOLUTION 09-65

PATIENT HEALTH INFORMATION

Introduced by:

Lee Smith Jr., M.D.

Referred to:

REFERENCE COMMITTEE I

Whereas, the emphasis on the confidentiality of health information has placed an impediment on patients to obtain copies of laboratory or other reports from the doctors that ordered the same; and

Whereas, to facilitate a patient's ability to be well-informed and to know all that has transpired from the most recent consultation; therefore, be it

RESOLVED, that the ISMA encourage physicians to routinely provide written lab results to patients as soon as available.