**RESOLUTION 19-01 DEADLINE FOR RESOLUTIONS**

Introduced by: Roberto Darroca, MD, Speaker of the House

Referred to: REFERENCE COMMITTEE 1

Whereas, the ISMA Bylaws currently provide that resolutions are to be submitted not later than 60 days prior to the first session of the House of Delegates to which the resolutions will be presented; and

Whereas, the current resolution deadline does not provide a sufficient amount of time for relevant ISMA committees and commissions to review, consider and research the issues presented in resolutions or to provide feedback to authors in advance of the first session of the House of Delegates to which the resolutions will be presented; therefore, be it

RESOLVED, that the ISMA Bylaws be amended to change the resolution deadline from 60 days to 120 days before the first session of the applicable House of Delegates, in order to provide relevant ISMA committees and commissions with sufficient time to review, consider, research and provide feedback on resolutions, as follows:

#### 3.020701 (b) Deadlines for Resolutions

Except as noted in 3.020701(c) and in 3.021102, all resolutions to be presented to the House of Delegates for action shall be prepared and submitted in writing or electronically to the Executive Vice President of the Association so that they will be received not later than ~~60~~120 days prior to the session of the House of Delegates to which the resolutions will be presented.

#### (c) Late Resolutions

Except for matters of extreme emergent nature, all late resolutions must be received by the Executive Vice President seven (7) days prior to the opening session of the House of Delegates. Those resolutions received after ~~60~~120 days prior to the first session of the House of Delegates will be referred to the Committee on Rules and Order of Business. The Committee on Rules and Order of Business shall submit a report to the House concerning all items considered by same with recommendation(s) limited to the appropriateness of consideration of said resolutions.

The Committee on Rules and Order of Business will meet approximately seven (7) days prior to the Annual Convention to consider resolutions that have been first submitted to the Committee together with a written statement setting forth the reasons why the resolution was not mailed to the Executive Vice President more than ~~60~~120 days prior to the first session of the House of Delegates and also setting forth in the written statement the reasons why the resolution is of such an emergency nature that it cannot wait until the next meeting of the House.

The report of the Committee on Rules and Order of Business shall be considered in the same manner as any other reference committee report. The House may accept or reject any recommendation of the Committee, which shall make recommendations on each resolution considered.

Discussion on the floor will be limited to one speaker in dissension with the Committee's recommendation. This discussion will be limited to the appropriateness of consideration and not the merits of the resolution itself.

Section 3.020701(b) may be suspended only upon a two-thirds affirmative vote of the House of Delegates when considering the report of the Committee on Rules and Order of Business. Each member of the House shall be furnished a copy of all proposed late resolutions for consideration of the report of the Committee on Rules and Order of Business.

**17.01 BYLAWS AMENDMENTS**

These Bylaws may be amended by resolution as in 3.020701(b), which shall be treated as any other proposed amendment, at any meeting of the House of Delegates by a majority vote of all the voting members present. Amendments to the Bylaws must be submitted to the Association ~~60~~120 days in advance of the meeting. These amendments must be presented to the Commission on Constitution and Bylaws prior to the meeting and are eligible for passage after lying on the table for one day.

**RESOLUTION 19-02 ELECTRONIC MEETING NOTICES**

Introduced by: J. Elizabeth Struble, MD, Chair; and

ISMA Board of Trustees

Referred to: REFERENCE COMMITTEE 1

Whereas, the ISMA Bylaws currently provide that proper notice for Board meetings is given if it is delivered in person, by telephone, mail or telegram; and

Whereas, the ISMA Chair of the Board, J. Elizabeth Struble, MD, and the ISMA Board of Trustees believe the ISMA Bylaws should be modernized to reflect that telegrams are no longer utilized and that, instead, electronic mail (“email”) is a reasonable and reliable means by which to provide notice of Board meetings; therefore, be it

RESOLVED, that the ISMA Bylaws be amended to include email instead of telegrams as a proper method for providing notice of Board meetings, as follows:

5.0405 **Meeting Notices**

Notice is given if delivered in person, by telephone, mail or ~~telegram~~ email. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, addressed to a Trustee (and other persons entitled to notice) at the Trustee's address then appearing on the records of the Association, with postage prepaid, and if given by ~~telegraph~~ email, shall be deemed delivered when ~~the telegram is delivered to the telegraph~~ company sent by email to a Trustee (and other persons entitled to notice) at the Trustee’s email address then appearing on the records of the Association.

Notice of any meeting and the object of business to be transacted at a meeting of the Board need not be given if waived in writing, or by ~~telegraph~~ email, mail, or telephone before, during, or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting except where attendance is for the express purpose of objecting to the transaction of any business because the meeting is unlawfully called or convened.

**RESOLUTION 19-03 MENTAL HEALTH PARITY**

Introduced by: David Diaz, MD, and Kyle Jamison, MD

Referred to: REFERENCE COMMITTEE 4

Whereas, in 2008, the Mental Health Parity and Addiction Equity Act (MHPAEA) was passed and became a federal law that requires large group health plans to have the same financial and treatment limitations for mental health/substance use disorder and medical/surgical benefits; and

Whereas, in 2010, the MHPAEA was amended by the Affordable Care Act to also apply to individual health insurance coverage; and

Whereas, researchers at the Congressional Budget Office reported that private insurers paid an average of 13-14% less than Medicare for in-network mental health services and 12% more than Medicare for the same services provided by other physician specialists; and

Whereas, in 2010, a study found that 3 in 10 plans used more stringent precertification and utilization management controls for mental health/substance use disorder than for medical/surgical conditions; and

Whereas, Indiana does not have the appropriate oversight mechanisms to ensure enforcement of MHPAEA; therefore, be it

RESOLVED, that ISMA support legislation to mandate parity of coverage for mental illness and substance use disorders; and be it further

RESOLVED, that ISMA support legislation to provide increased state-level accountability and enforcement of the Mental Health Parity and Addiction Equity Act.

**RESOLUTION 19-04 REPEAL OF RESOLUTION 18-60, MEDICARE PAYMENT SYSTEM CHANGES**

Introduced by: Robert Flint, MD

Referred to: REFERENCE COMMITTEE 2

Whereas, in 2018, Resolution 18-60 was introduced in the House of Delegates by this author because the Centers for Medicare and Medicaid Services (CMS) was proposing changes to the Medicare payment system in the Medicare Physician Fee Schedule that would result in one payment amount for outpatient office visits, regardless of complexity; and

Whereas, Resolution 18-60 was adopted by the 2018 House of Delegates, directing ISMA to contact CMS with a specific compromise on the billing levels and also to ask the AMA to support ISMA’s compromise proposal; and

Whereas, shortly after adoption of Resolution 18-60, CMS issued the 2019 Medicare Physician Fee Schedule Final Rule, and that final rule addressed the concerns raised by Resolution 18-60 by updating the reimbursement levels of evaluation and management office and outpatient visits by consolidating levels two through four while maintaining the current payment rate for level five; providing new add-on CPT codes to account for additional resources used in primary care, extended services and complex specialized care previously indirectly documented through higher billing level; and delayed the changes until 2021 to allow stakeholders time to adjust; and

Whereas, in its 2020 Medicare Physician Fee Schedule Proposed Rule, CMS has proposed additional changes to the Medicare payment system in the Medicare Physician Fee Schedule for 2021, many of which are based on recommendations of the AMA; and

Whereas, the author of Resolution 18-60 and ISMA staff believe it is no longer necessary for ISMA to contact Seema Verma or involve the AMA, as directed by Resolution 18-60; therefore, be it

RESOLVED, that the House of Delegates direct ISMA to not carry out Resolution 18-60 and to repeal Resolution 18-60 as moot, as follows:

~~RESOLVED, that ISMA directly contact Seema Verma, administrator of the Centers for Medicare & Medicaid Services (CMS), with a compromise proposal for reducing the current number of billing levels for new and follow-up outpatient visits, including:~~

1. ~~Continue level 1 new and follow-up outpatient encounters with no change in current reimbursement or documentation requirements.~~
2. ~~Change from the four remaining service levels to use of what are currently service levels 2 and 4 for both new and follow-up outpatient encounters.~~
3. ~~Reimburse lower-level new patients at$95; reimbursement for higher-level new patients would be $190, and lower-level follow-up reimbursement would be $60. For the higher-level follow up, reimbursement would be $130.~~
4. ~~Documentation requirements for these new levels will remain the same as current levels 2 and 4;~~

~~and be it further~~

~~RESOLVED, that the ISMA delegation to the AMA request that the AMA also support the compromise proposal, suggested by the ISMA, in a formal letter to CMS.~~

**RESOLUTION 19-05 E-PRESCRIBING**

Introduced by: Steven Tharp, MD; and Heidi M. Dunniway, MD

Referred to: REFERENCE COMMITTEE 2

Whereas, e-prescribing for controlled substances covered under Medicare part D will be mandatory starting in 2021 under H.R. 6[[1]](#footnote-1), and many states have enacted laws requiring e-prescribing for all prescription medications; and

Whereas, under Indiana Code section 25-1-9.3-7, after Dec. 31, 2020, a prescriber must issue all prescriptions for controlled substances electronically unless certain exceptions apply[[2]](#footnote-2); and

Whereas, in 2010, the Drug Enforcement Administration issued an Interim Final Rule permitting practitioners to write prescriptions for controlled substances electronically[[3]](#footnote-3); and

Whereas, Indiana Code section 35-48-3-9 was updated in 2011 and again in 2013 to permit the electronic prescribing of controlled substances[[4]](#footnote-4); and

Whereas, e-prescribing can place an immense financial, training and time-related burden on physicians and practices[[5]](#footnote-5),[[6]](#footnote-6); and

Whereas, ISMA has established a task force to ensure that effective exemptions are established in ISMA policy and in state laws and regulations to minimize the burdens of new requirements and to ensure adherence to existing ISMA and AMA policy regarding physician prescription practices; and

Whereas, exemptions are an appropriate way to protect patients from potential safety concerns related to insecure patient data and technology-related issues with receiving medications in an appropriate time frame; therefore, be it

RESOLVED, that ISMA support the following exemptions to any future e-prescribing mandate at the state level:

* Physicians who write no more than 100 applicable prescriptions per year
* Locum tenens physicians or physicians practicing in a location other than their primary office on a temporary basis
* If the physician determines that it is in the best interest of the patient, or the patient requests a written prescription, to compare prescription drug prices among area pharmacies and documents such in the medical record
* If the physician reasonably determines that it would be impractical for the patient to obtain an electronic prescription in a timely manner and such delay would adversely affect the patient’s medical condition
* Physicians who do not utilize electronic medical records
* Compounded prescriptions
* Prescriptions with directions longer than 140 characters
* Physicians who are volunteering or providing uncompensated care

**RESOLUTION 19-06 MEDICAL STUDENT AND RESIDENT/FELLOW REPRESENTATION ON THE COMMISSION ON LEGISLATION**

Introduced by: Kimberly Chernoby, MD; Kelsey Quin and Caitlin Harmon, ISMA Medical Student Society; and ISMA Resident and Fellow Society

Referred to: REFERENCE COMMITTEE 1

Whereas, medical students, residents, and fellows currently make up approximately 17% of ISMA membership; and

Whereas, the Medical Student Society and the Resident and Fellow Society have dedicated seats on the ISMA Board of Trustees; and

Whereas, medical students, residents, and fellows have a proven record of introducing policy in this Association that goes on to become legislative priority; and

Whereas, there are currently no dedicated seats on the ISMA Commission on Legislation for representatives from the Medical Student Society or Resident and Fellow Society; therefore, be it

RESOLVED, that the ISMA Bylaws be amended to create dedicated seats on the Commission on Legislation for one representative from the Medical Student Society and one representative from the Resident and Fellow Society, with full participatory and voting rights, as follows:

**7.03 COMMISSION STRUCTURE**

The President may appoint one commission member for each 600 regular members of a trustee medical district, or a major fraction thereof; but in any event, each district shall have one member on each commission.

The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise.

The President may appoint a maximum of five (5) At-Large members, one of whom may be a ~~resident physician~~ representative from the Resident and Fellow Society and one of whom may be a ~~medical student~~ representative from the Medical Student Society, for a term of one year, with the right to vote, to each commission. The President shall appoint the Chairman of each commission. The Commission Chairman shall appoint a Vice Chairman.

In addition to the above-mentioned appointments, the Commission on Medical Education may maintain in its membership CME professionals needed to carry out its duties. They will be appointed by the Chairman of the Commission with the approval of the physician members. They may vote at Commission meetings. They will have three-year terms that may be renewed or terminated by the Commission Chairman with the approval of the physician members.

The President shall also appoint for one-year terms one (1) representative from the Medical Student Society and one (1) representative from the Resident and Fellow Society to serve as members of the Commission on Legislation, with the right to vote.

**RESOLUTION 19-07 MEDICAL PROVIDER QUALIFICATION: TRUTH AND TRANSPARENCY**

Introduced by: Ben Vickery, IUSM-IV, and William W. Pond, MD, Fort Wayne Medical Society

Referred to: REFERENCE COMMITTEE 3

Whereas, medical and osteopathic physicians have traditionally been known

by the title “doctor,” which is well-respected due to the responsibility,

compassion, rigorous selection, and 12 to15 years of postsecondary

training required before being able to independently practice medicine; and

Whereas, an increasing number of nonphysician midlevel health care providers have received limited, increased responsibility with six to eight years of postsecondary training, but have endeavored to increase their credibility by claiming the title “doctor”; and

Whereas, the claiming of “doctor” by such midlevel providers, such as pharmacists (Pharm D), nurses (DNP, DNS, PhD, or EdD), audiologists (AUD), speech-language pathologists (SLPD or PhD) or therapists (DPT), results in ambiguity for patients as to the level of responsibility, training and skill set of their health care provider; and

Whereas, a 2018 AMA survey showed only 55% of respondents found it easy to identify their physicians based on title and advertising of their position, and 79% supported legislation to clearly designate education level, skills and training of health care practitioners; and

Whereas, additional qualifications for midlevel providers should be encouraged and recognized while not misleading patients; and

Whereas, Indiana does not have regulations regarding the identification or advertising of health care professionals, while other states, such as Georgia, Texas and Maryland, do have guidance requiring health care practitioners to identify themselves, their qualification and licensure; therefore, be it

RESOLVED, that ISMA support initiatives to provide clear, defined guidelines for truth and transparency in advertising and identification of health care practitioners; and be it further

RESOLVED, that ISMA commend the work of those who have worked so diligently this past year with leaders of medical specialty organizations to develop model legislation and policies that support truth in advertising and identification for health care practitioners.

**RESOLUTION 19-08 HOSPITAL PROTOCOLS FOR AIR MEDICAL TRANSPORT**

Introduced by: Colton Junod, ISMA-MSS

Referred to: REFERENCE COMMITTEE 4

Whereas, an estimated 400,000 patients are transferred via helicopter annually in the United States; and   
  
Whereas, rural hospitals and EMS providers across Indiana rely on helicopters to transfer critical patients to tertiary care centers; and   
  
Whereas, the levels of care / capabilities provided by each air medical transport provider are not equal; and   
  
Whereas, rural physicians and first responders are often unaware of these differences; therefore, be it

RESOLVED, that ISMA encourage all Indiana hospitals, ground emergency medical services agencies and 911 centers to create protocols to determine which air medical service should be contacted when requested. The factors that should be taken into consideration include: geographical distance, helicopter size, weather capabilities (IFR vs. VFR), blood products and specialized equipment.

**RESOLUTION 19-09 ADVANCING GENDER EQUITY IN MEDICINE**

Introduced by: Theresa Rohr-Kirchgraber, MD;

and Kimberly Chernoby, MD, JD

Referred to: REFERENCE COMMITTEE 3

# Diversity and Progress

Whereas, workforce diversity is defined as the presence of people from many different backgrounds, and workforce inclusion represents how these individuals are able to equitably be promoted, compensated and supported in their careers1; and

Whereas, women physicians have documented gaps in compensation and career advancement at all levels, and these gaps widen over their career trajectory2; and

Whereas, the published literature has documented that progress for women physicians has been slower than would be anticipated given the growing numbers of women in medicine3; and

Whereas, traditional justifications for the lack of or slow progress for women in medicine have been refuted4 and there has been a shift away from focusing on the women themselves and toward addressing institutional and structural bias and other barriers5; and

Whereas, there is a continuum of documented disparities for women in medicine, from micro- to macro-inequities,6 and it is theorized that a culture that supports pervasive micro-inequities provides opportunities for macro-inequities to flourish; and

Whereas, workforce disparities for women physicians may negatively impact patients’ ability to receive services and the quality of the services provided7; and

Whereas, reports have documented gaps in medical societies’ efforts to tackle workforce and patient health disparities8 and have called on them to more critically assess their efforts through metrics, outcomes and reporting methodology that is consistent with that used in evidence-based medicine1; and

Whereas, physicians are working together in a grassroots effort to encourage their organizations to be better allies (e.g., national campaigns such as the Societies As Allies Campaign9 and the Be Ethical Campaign10; and

# Unequal Pay

Whereas, recent studies have demonstrated that there are persistent pay disparities for women physicians that begin early in their careers and across practice settings11,12, specialties and positions13,14 – with the gaps more pronounced for mid- and late-career women; and

Whereas, gender pay disparities exist even when other factors are accounted for12,14,15, including differences in age, years of experience, specialty, reported work hours, clinical productivity, research productivity and faculty rank; and

Whereas, gaps in compensation between men and women physicians widen over the physician’s career trajectory, particularly for women with intersectionality (those who also identify with other underrepresented groups)16; and

Whereas, a recently published analysis of salary differences at 24 U.S. public medical schools found that the annual salaries of female physicians were $19,879 (8%) lower than the salaries of male physicians, and this difference persisted through all faculty ranks9; and

Whereas, the 2018 Medscape Physician Compensation Report17 found that male primary care physicians earned almost 18% more than their female counterparts, and among specialists, that gap widened to about 3%; and

Whereas, the city of Chicago can no longer ask about salary history on employment applications, part of a growing effort nationwide to improve pay equality between men and women18; and

Whereas, studies have historically found a payment disparity gap among male and female physicians within the same specialty19,20, and this payment disparity continues to exist in all specialties of medicine in 201821,22; and

Whereas, among cohorts of equal training and experience, adjusting for variables including work hours, calls, vacation, gender and academic versus non-academic practice, women held less-advanced academic positions, earning significantly less compensation 10 years after graduation23; and

Whereas significant differences in salary also exist among male and female physicians with faculty appointments at U.S. public medical schools, even after accounting for age, experience, specialty faculty rank and measures of research productivity and clinical revenue11; and

Whereas, the Lilly Ledbetter Fair Pay Act took effect in 2009, restoring protection against pay discrimination that had been undermined by a recent U.S. Supreme Court decision24; and

Whereas, the Massachusetts Equal Pay Act took effect July 1, 201825 requiring, among other things, equal pay for comparable work, non-prohibition of voluntary wage disclosure to others, prohibitions on asking about salary history and prohibitions on retaliating against employees who exercise their rights under the Act; and

Organizational Efforts

Whereas, the National Institutes of Health (NIH) has speaker guidelines that focus on the inclusion of women in medicine at scientific conferences26 and publishes workforce inclusion metrics for women in medicine such as grant funding27; this has not been the practice of medical societies; and

Whereas, the Association of Academic Physiatrists (AAP) is the first medical society to report in a medical journal its gender inclusion metrics and provide a plan to achieve equitable inclusion in the future28; and

Whereas, the American College of Physicians (ACP) recently published a position paper29 titled “Achieving Gender Equity in Physician Compensation and Career Advancement,” clarifying the organization’s positions and recommendations regarding gender equity in medicine; and

Whereas, the Association of Women Surgeons (AWS) recently published a position paper10 titled “Strategies for Identifying and Closing the Gender Salary Gap in Surgery”; and

Whereas, the National Academies of Science, Engineering, and Medicine (NASEM) published a report in 2004, “Achieving XXcellence in Science: Role of Professional Societies in Advancing Women in Science”30; and

Whereas, the NASEM published a report in 2018, “Sexual Harassment of Women: Climate, Culture, and Consequences in Academic Sciences, Engineering, and Medicine”31; and

Whereas, the National Institutes of Health has formally apologized for its failure to address sexual harassment in science and is taking steps to address it32; and

Whereas, Salesforce.com, an American cloud computing company, recently undertook regular assessments and adjusted salaries accordingly in order to close pay gaps among employees based on gender and ethnicity33 with companies like Adobe, Apple, Facebook, Intel, and Starbucks following suit34; and

Whereas, medical societies have unique opportunities to support underrepresented physician members with career enhancing opportunities35; and

Whereas, women physicians have been underrepresented for medical society-affiliated career enhancing opportunities including, but not limited to, presidential leadership36, journal editorial boards37, conference speakers38, and recognition awards, which are directly linked to promotion and part of the formal criteria for promotion at most academic institutions; and

# American Medical Association (AMA) and Other State Efforts

Whereas, the AMA and AMA’s Women Physicians Section have made concerted efforts to highlight the disparity of physician payment by gender in the United States today and to increase the influence of women physicians in leadership roles in medicine39; and

Whereas, the AMA Women Physicians Section supports a number of important initiatives, including Women in Medicine Month, the Women in Medicine Symposium and the Joan F. Giambalvo Fund for the Advancement of Women; and

Whereas, AMA policy H-525.992 supports “the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine” , and AMA policy D-200.981 notes that the organization “will collect and publicize information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession”; and

Whereas, the AMA had strong existing policy on equal pay in medicine prior to June 201840, including (1) further “study [of] gender differences in income and advancement trends, by specialty, experience, work hours and other practice characteristics,” (2) “develop[ment of] programs to address disparities where they exist,” (3) “urg[ing] medical schools, hospitals, group practices and other physician employers to institute and monitor transparency in pay levels in order to identify and eliminate gender bias and promote gender equity throughout the profession,” (4) “collect[ing] and publiciz[ing] information on best practices in academic medicine and non-academic medicine that foster gender parity in the profession, and (5) provid[ing] training on leadership development, contract and salary negotiations and career advancement strategies, to combat gender disparities as a member benefit”; and

Whereas, the AMA in June 2018 passed the most comprehensive gender equity policy to date, “Advancing Gender Equity in Medicine” (D-65.989), which states that (1) Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual Meeting; (2) Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement; (3) Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits; (4) Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity; and (5) Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work”; and

Whereas, in December 2018, the Massachusetts Medical Society (MMS) endorsed the AMA’s gender equity principles by passing equivalent policy titled “Advancing Gender Equity in Medicine”; and

Indiana State Medical Association Efforts

Whereas, ISMA has policy that states:

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: Updated December 2018 72 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; and

Whereas, ISMA does not have comparable policies to the AMA on these important topics; therefore, be it

RESOLVED, that ISMA draft and disseminate a report detailing its positions and recommendations for gender equity in medicine, including clarifying principles for state and specialty societies, academic medical centers and other entities that employ physicians, to be submitted to the House for consideration at the 2020 Annual State Meeting; and be it further

RESOLVED, that ISMA:

1. Advocate for institutional, departmental and practice policies that promote transparency in defining the criteria for initial and subsequent physician compensation
2. Advocate for pay structures based on objective, gender-neutral objective criteria
3. Encourage a specified approach, sufficient to identify gender disparity, to oversight of compensation models, metrics, and actual total compensation for all employed physicians
4. Advocate for training to identify and mitigate implicit bias in compensation determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement;

and be it further

RESOLVED, that ISMA recommend as immediate actions to reduce gender bias (a) eliminate of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits; and be it further

RESOLVED, that ISMA collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our Indiana State Medical Association, including the Board of Trustees, councils and section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates, beginning at the 2020 meeting and continuing yearly thereafter, with recommendations to support ongoing gender equity efforts; and be it further

RESOLVED, that ISMA commit to pay equity across the organization by encouraging the Executive Vice President to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

**FISCAL NOTE:** *The introduced resolution proposes that ISMA “establish educational programs” and “host a workshop” to achieve the desired outcomes. Additional specificity is needed to determine scope and scale of such offerings; costs could range from $5,000 to $15,000 depending upon delivery method and length of offerings. Costs include, but are not limited to, event promotion, content development, procuring faculty, program delivery and disseminating reports.*

Editor’s Note

This resolution, along with the cited resources, was largely written by Dr. Julie Silver and Dr. Michael Sinha, and the authors would like to acknowledge their important contribution. Appropriate changes were made by Theresa Rohr-Kirchgraber, MD, and Kimberly Chernoby, MD, JD, the lead sponsors, as part of an ongoing effort by the American Medical Women’s Association known as Revolution by Resolution, aimed at bringing gender equity resolutions to state and specialty medical societies.

References

1 Silver JK, Slocum CS, Bank AM, et al. Where Are the Women? The Underrepresentation of Women Physicians Among Recognition Award Recipients From Medical Specialty Societies. *PM R.* 2017;9(8):804-815.

1. Carr PL, Gunn CM, Kaplan SA, Raj A, Freund KM. Inadequate progress for women in academic medicine: findings from the National Faculty Study. *J Womens Health (Larchmt).* 2015;24(3):190-199.
2. Helitzer DL, Newbill SL, Cardinali G, Morahan PS, Chang S, Magrane D. Changing the Culture of Academic Medicine: Critical Mass or Critical Actors? *J Womens Health (Larchmt).* 2017;26(5):540-548.
3. Carnes M, Morrissey C, Geller SE. Women's health and women's leadership in academic medicine: hitting the same glass ceiling? *J Womens Health (Larchmt).* 2008;17(9):1453-1462.
4. Lillemoe KD. Surgical Mentorship: A Great Tradition, But Can We Do Better for the Next Generation? *Ann Surg.* 2017;266(3):401-410.
5. Silver JK, Rowe M, Sinha MS, Molinares DM, Spector ND, Mukherjee D. Microinequities in Medicine. PM R. 2018 Oct;10(10):1106-1114.
6. <https://hbr.org/2018/08/how-discrimination-against-female-doctors-hurts-patients>
7. Peek ME, Wilson SC, Bussey-Jones J, et al. A study of national physician organizations' efforts to reduce racial and ethnic health disparities in the United States. *Acad Med.* 2012;87(6):694-700.
8. #SocietiesAsAllies - Twitter Search. 2018; Available at <https://twitter.com/search?q=%23SocietiesAsAllies&src=typd>.

10 Silver JK. Be Ethical: A Call to Healthcare Leaders: Ending Workforce Disparities is an Ethical Imperative. Sept 2018. Available at <http://sheleadshealthcare.com/wp-content/uploads/2018/09/Be-Ethical-Campaign.pdf.>

11 Jena AB, Olenski AR, Blumenthal DM. Sex Differences in Physician Salary in US Public Medical Schools. JAMA Intern Med. 2016 Sep 1;176(9):1294-304.

12 Sanfey H, Crandall M, Shaughnessy E, Stein SL, Cochran A, Parangi S, Laronga C. Strategies for Identifying and Closing the Gender Salary Gap in Surgery. J Am Coll Surg. 2017 Aug;225(2):333-338.

13 Willett LL, Halvorsen AJ, McDonald FS, Chaudhry SI, Arora VM. Gender differences in salary of internal medicine residency directors: a national survey. Am J Med. 2015 Jun;128(6):659-65.

14 Jagsi R, Griffith KA, Stewart A, et al. Gender differences in the salaries of physician researchers. JAMA 2012;307: 2410e2417.

15 Ly DP, Seabury SA, Jena AB. Differences in incomes of physicians in the United States by race and sex: observational study. BMJ. 2016;353:i2923.

16 Carr PL, Gunn CM, Kaplan SA, Raj A, Freund KM. Inadequate progress for women in academic medicine: findings from the National Faculty Study. J Womens Health (Larchmt). 2015;24(3):190-199.

17 Kane L. Medscape Physician Compensation Report 2018. Available at: https[://www.medscape.com/slideshow/2018-compensation-overview-6009667.](http://www.medscape.com/slideshow/2018-compensation-overview-6009667)

18 Chicago Tribune: “Emanuel moves to boost gender pay equity.” April 12, 2018.

19 MEDSCAPE 2016 Physician Compensation Report: https://[www.medscape.com/features/slideshow/compensation/2016/public/overview](http://www.medscape.com/features/slideshow/compensation/2016/public/overview)

20 MEDSCAPE 2017 Physician Compensation Report: [www.medscape.com/slideshow/compensation-2017-overview-6008547](http://www.medscape.com/slideshow/compensation-2017-overview-6008547)

21 MEDSCAPE 2018 Physician Compensation Report: https://[www.medscape.com/slideshow/2018-compensation-](http://www.medscape.com/slideshow/2018-compensation-) overview-6009667

22 Doximity: Second Annual Physician Compensation Report. March 2018 https[://www.doximity.com/press\_releases/national\_research\_study\_finds\_large\_gaps\_in\_us\_physician\_compensatio](http://www.doximity.com/press_releases/national_research_study_finds_large_gaps_in_us_physician_compensatio)n

23 Singh A, Sastri S, Burke C. Do Gender Disparities Persist in Gastroenterology after Ten Years of Practice? Am J Gastroenterol. Vol. 103, pages1589–1595 (2008)

24 <https://nwlc.org/resources/lilly-ledbetter-fair-pay-act/>

25 https[://w](http://www.mass.gov/service-details/learn-more-about-the-massachusetts-equal-pay-act)ww[.m](http://www.mass.gov/service-details/learn-more-about-the-massachusetts-equal-pay-act)a[ss.gov/service-details/learn-more-about-the-massachusetts-equal-pay-act](http://www.mass.gov/service-details/learn-more-about-the-massachusetts-equal-pay-act)

26 National Institutes of Health. *Guidelines for Inclusion of Women, Minorities, and Persons with Disabilities in NIH- Supported Conference Grants.* 2003. NOT-OD-03-066.

27 Ginther DK, Kahn S, Schaffer WT. Gender, Race/Ethnicity, and National Institutes of Health R01 Research Awards: Is There Evidence of a Double Bind for Women of Color? *Acad Med.* 2016;91(8):1098-1107.

28 Silver JK, Cuccurullo S, Ambrose AF, et al. Association of Academic Physiatrists women’s task force report. *Am J Phys Med Rehabil.* 2018;(accepted and in press).

29 Butkus R, Serchen J, Moyer DV, Bornstein SS, Hingle ST. Achieving Gender Equity in Physician Compensation and Career Advancement: A Position Paper of the American College of Physicians. *Ann Int Med.* 2018.

30 https[://www.nap.edu/catalog/10964/achieving-xxcellence-in-science-role-of-professional-societies-in-advancing](http://www.nap.edu/catalog/10964/achieving-xxcellence-in-science-role-of-professional-societies-in-advancing)

31 <http://sites.nationalacademies.org/shstudy/index.htm>

32 NIH apologizes for its failure to address sexual harassment in science. STAT. https[://w](http://www.statnews.com/2019/02/28/nih-sexual-harassment-science/)ww[.statn](http://www.statnews.com/2019/02/28/nih-sexual-harassment-science/)e[ws.com/2019/02/28/nih-sexual-harassment-science/](http://www.statnews.com/2019/02/28/nih-sexual-harassment-science/)

33 Salesforce Is Focused on Erasing the Gender Pay Gap. Available at [http://fortune.com/video/2018/04/13/salesforce-is-focused-on-erasing-the-gender-pay-gap/.](http://fortune.com/video/2018/04/13/salesforce-is-focused-on-erasing-the-gender-pay-gap/)

34 How These Major Companies Are Getting Equal Pay Right. Available at <http://fortune.com/2018/04/09/equal-pay-> companies-starbucks-apple/.

35 National Research Council. *Achieving XXcellence in Science: Role of Professional Societies in Advancing Women in Science: Proceedings of a Workshop.* Washington, DC: The National Academies Press; 2004.

36 Silver JK, Ghalib R, Poorman JA, Al-Assi D, Parangi S, Bhargava H, Shillcutt SK. Analysis of gender equity in leadership of physician-focused medical specialty societies (2008-2017). JAMA Intern Med. 2019. Jan 7.

1. Amrein K, Langmann A, Fahrleitner-Pammer A, Pieber TR, Zollner-Schwetz I. Women underrepresented on editorial boards of 60 major medical journals. *Gend Med.* 2011;8(6):378-387.
2. Johnson CS, Smith PK, Wang C. Sage on the Stage: Women's Representation at an Academic Conference. *Pers Soc Psychol Bull.* 2017;43(4):493-507.
3. American Medical Association: https[://w](http://www.ama-assn.org/about/women-physicians-section-wps)ww[.a](http://www.ama-assn.org/about/women-physicians-section-wps)m[a-assn.org/about/women-physicians-section-wps](http://www.ama-assn.org/about/women-physicians-section-wps)

40 AMA Policy Finder. Gender Disparities in Physician Income and Advancement, D-200.981.

**RESOLUTION 19-10 INCREASING PAYMENTS TO PHYSICIANS PROVIDING MEDICAID SERVICES**

Introduced by: Tony GiaQuinta, MD, FAAP; Cynthia Nassim, MD, FAAP; Mary McAteer, MD; Penny Kallmyer, MD; and Indianapolis Medical Society

Referred to: REFERENCE COMMITTEE 3

Whereas, providing high-quality care to patients in a medical home is in the best interest of patient health; and

Whereas, it is critical for patients to have access to a medical home that is in their community; and

Whereas, pediatricians, family physicians, and other primary care providers who treat children often have a large patient population who are serviced through Medicaid health insurance plans, including Hoosier Healthwise plans; and

Whereas, primary care providers in Indiana who treat children through Medicaid and Hoosier Healthwise plans are only paid 75% of what Medicare would pay for similar services; and

Whereas Healthy Indiana Plan (HIP) 2.0 plans that service adults over the age of 19 are required to pay 100% of what Medicare would pay for similar services; and

Whereas the care of children and adults should be treated and compensated equally; and

Whereas, lower Medicaid and Hoosier Healthwise payment rates often force primary care providers to choose between either not accepting patients on Medicaid, closing their private practices or treating patients at a loss; and

Whereas, national data demonstrates that increasing payment rates for services provided through Medicaid results in a significant increase to participation in Medicaid by office-based pediatric providers; and

Whereas, having fewer primary care providers seeing patients through Medicaid and Hoosier Healthwise plans decreases the quality of care for Indiana residents and makes it harder for them to receive care in a medical home; therefore, be it

RESOLVED, that ISMA encourage and support legislation in Indiana to raise payment rates for providers who treat patients through Medicaid and Hoosier Healthwise plans to match Healthy Indiana Plan (HIP) 2.0 and Medicare rates.

**RESOLUTION 19-11 TAX ON SUGAR-SWEETENED BEVERAGES**

Introduced by: Alan Alvarez de Sotomayor, ISMA-MSS

Referred to: REFERENCE COMMITTEE 4

Whereas, Indiana has the 12th highest adult obesity rate in the country and ninth highest obesity rate for youth aged 10-17. Additionally, it is ranked 11th highest for adult-onset diabetes at a staggering 11.8% (as of 2017)[[7]](#footnote-7). Obesity is estimated to cost the state over $8 billion annually due to labor market costs, excess health care costs and loss in economic output due to premature mortality[[8]](#footnote-8); and   
  
Whereas, overconsumption of sweetened sugars is a risk factor for obesity, type 2 diabetes and cardiovascular disease[[9]](#footnote-9); and   
  
Whereas, a study conducted in California one year after they introduced their soda tax in Berkeley found a 21% decrease in the consumption of sugar-sweetened beverages in low-income neighborhoods[[10]](#footnote-10) followed by a 52% decrease in consumption of sugar-sweetened beverages three years after implementation[[11]](#footnote-11). An additional systematic review noted that price increases (i.e. taxes) on sugar-sweetened beverages have moderate-certainty evidence[[12]](#footnote-12) for a decrease in consumption; therefore, be it

RESOLVED, that ISMA seek and support legislation that would implement a $0.01-per-ounce tax on sugar-sweetened beverages including soda, energy, sports, and fruit-flavored drinks, as a means to curb sugar overconsumption among Hoosiers.

**RESOLUTION 19-12 MANDATORY UNIVERSAL NEWBORN SCREENING FOR CONGENITAL HEART DISEASE**

Introduced by: Maria Del Rio Hoover, MD; and William A. Engle, MD

Referred to: REFERENCE COMMITTEE 4

Whereas, since 2012, screening for critical congenital heart disease (CCHD) in Indiana has provided a safety net to provide early detection at 24-48 hours of age of healthy appearing neonates who are born with heart disease not recognized prior to delivery; and

Whereas, 410 Indiana Administrative Code 3-3-3.5, Pulse Oximetry Measurement for Critical Congenital Heart Disease,” as adopted in 2018, requires that “every newborn shall be given a pulse oximetry screening examination not earlier than twenty-four (24) and not later than forty-eight (48) hours after birth”; and

Whereas, if the newborn does not pass a series of readings as prescribed by the rule, the newborn must be immediately be referred for “cardiology evaluation” ; and

Whereas, the rule includes sick premature and term infants admitted to neonatal intensive care units (NICUs) and with prenatally diagnosed congenital heart disease (CHD); and

Whereas, premature and term infants with respiratory illnesses often require supplemental oxygen in the first days to months after birth and are frequently managed to achieve safe oxygen saturation targets that would cause screening pulse oximetry to be reported as positive; and

Whereas, premature and term infants have routinely received CCHD screening prior to discharge or at an earlier time in their hospital course if clinically indicated prior to discharge; and

Whereas, infants with prenatally diagnosed CHD usually receive confirmatory echocardiography and pediatric cardiology consultation in the first days after birth; and

Whereas, screening neonates admitted to the NICU or with prenatally diagnosed CHD in accordance with this new rule substantially increases the testing and evaluation burden for several thousand neonates admitted to (NICUs) in Indiana; and

Whereas, strict adherence to 410 Indiana Administrative Code 3-3-3.5 means that many neonates will receive unnecessary testing, leading to increased spending without a well-defined benefit; therefore, be it

RESOLVED, that ISMA seek to amend, either through legislation or rule, 410 Indiana Administrative Code 3-3-3.5 as follows:

1. Identify or define special populations, including infants who are premature, admitted to the neonatal intensive care unit, or require oxygen;
2. Modify the screening population either by allowing for exclusion of those special populations from testing at 24 to 48 hours of age or by including all infants in the screening program, but modifying the screening algorithm to account for those special populations; and
3. Clarifying what constitutes a “cardiology evaluation.”

**RESOLUTION 19-13 VALUE-BASED HEALTH CARE**

Introduced by: Stephen Tharp, MD, Chair, Commission on Legislation

Referred to: REFERENCE COMMITTEE 3

Whereas, the proliferation of value-based payment methods, especially through Medicare payment initiatives (e.g. Primary Cares Initiative), has indicated a potential for substantial growth in revenue for physician practices; and

Whereas, hospital price increases have been a major driver of the growth in health care spending to $3.5 trillion[[13]](#footnote-13), and Indiana is among the states with the highest rates relative to Medicare (311% of Medicare on average)[[14]](#footnote-14); and

Whereas, Indiana insurers and hospitals (e.g. Franciscan Health) and the Indiana Hospital Association have expressed support for value-based health care [[15]](#footnote-15); and

Whereas, in 2018, the AMA developed guidelines and principles for policy related to pay-for-performance models to protect physician practices from undue burden, as well as reaffirmed policy promoting pay-for-performance incentives and “value-based decision-making” at all case complexity levels[[16]](#footnote-16),[[17]](#footnote-17); and

Whereas, fair and ethical value-based health care programs are patient-centered and link evidence-based performance measures to financial incentives; therefore, be it

RESOLVED, that ISMA oppose health care reform initiatives that divert physician time away from clinical care and are not patient-centered, such as those requiring increased administrative burden; and be it further

RESOLVED, that ISMA endorse value-based health care initiatives that align with the AMA Pay for Performance Principles and Guidelines ([Policy H-450.947](https://policysearch.ama-assn.org/policyfinder/detail/Pay-for-Performance%20Principles%20and%20Guidelines%20H-450.947?uri=%2FAMADoc%2FHOD.xml-0-4071.xml)).

**RESOLUTION 19-14 REDUCING THE PSYCHOLOGICAL TRAUMA OF FOSTER CARE CHILDREN**

Introduced by: Caitlin Harmon, ISMA-MSS

Referred to: REFERENCE COMMITTEE 4

Whereas, in September 2017, there were 20,394 children in Indiana living in out-of-home placement; and

Whereas, the average number of days that a child, separated from their parents by the Department of Child Services (DCS), spends in out-of-home placement is 610 days at one time; and

Whereas, Indiana DCS separated children from their parents and placed them in out-of-home placement at nearly twice the national rate in 2018; and

Whereas, the national rate of children in care is 3.6 per 1,000, but in Indiana, it is 13 per 1,000; and

Whereas, the large number of children and families involved in the foster care system in Indiana can be directly correlated to the current opioid epidemic; and

Whereas, there are large variations in how DCS cases are managed and in how DCS functions throughout the state, often leading to vastly different outcomes for very similar cases; and

Whereas, research has shown that children who were involved in the foster care system continue to struggle in areas such as income, health, substance abuse and criminal involvement throughout their lives; and

Whereas, former foster care youth have been shown to have a much higher rate of mental health disorders as compared to the general population, including a rate of post-traumatic stress disorder comparable to that of military veterans; therefore, be it

RESOLVED, that ISMA support the development and use of other resources for families dealing with substance abuse, as an alternative to immediate Department of Child Services involvement in appropriate cases; and be it further

RESOLVED, that ISMA support increased standardization of Department of Child Services case management and execution, with the goal of decreasing negative long-term outcomes and minimizing the psychological trauma of the children and families involved.

<https://www.in.gov/dcs/files/PI_Length_Of_Stay_Out_Of_Home_Placement_6-19.pdf>

<https://www.in.gov/dcs/files/PI_Locally_Placed_CHINS_6-19.pdf>

<https://www.adoptioncouncil.org/blog/2018/01/stats-show-our-nations-foster-care-system-is-in-trouble>

<https://www.ibj.com/articles/67345-report-indiana-putting-children-in-foster-care-at-twice-national-rate>

<https://cbs4indy.com/2018/06/18/consultants-release-findings-after-6-month-review-of-issues-at-indiana-dcs/>

<https://www.sciencedirect.com/science/article/pii/S019074091730213X>

<https://www.casey.org/nw-youth-outcomes/>

<https://www.in.gov/dcs/files/IndianaEvaluationReportCWGFinal.pdf>

**RESOLUTION 19-15 NICOTINE REPLACEMENT THERAPY FOR MINORS**

Introduced by: Mary Ian McAteer, MD; and the Indianapolis Medical Society

Referred to: REFERENCE COMMITTEE 2

Whereas, the number of children and adolescents under the age of 18 that are using, being exposed to and becoming addicted to tobacco and nicotine is increasing at an alarmingly rapid rate; and

Whereas, most current evidence-based nicotine cessation treatment options are only available for those 18 and older; and

Whereas, additional treatment options are needed to address these patients; therefore, be it

RESOLVED, that ISMA seek immediate and thorough study of the use of all forms of nicotine delivery, as well as all treatment options in populations under the age of 18; and be it further

RESOLVED, that ISMA align support for future legislative action to protect providers for off-label use of tobacco and nicotine cessation products until they become approved for minors; and be it further

RESOLVED, that ISMA seek AMA policy and federal regulation that encourages manufacturers of current nicotine delivery and treatment therapy approved for adults to study their products for the use in populations under the age of 18.

**RESOLUTION 19-16 STATEWIDE SYRINGE SERVICE PROGRAM**

Introduced by: Mary Ian McAteer, MD; and Indianapolis Medical Society

Referred to: REFERENCE COMMITTEE 2

Whereas, approximately six counties in Indiana have syringe service programs that have been successful in reducing HIV, hepatitis B, and hepatitis C infection rates; and

Whereas, syringe service programs have reduced the burden in emergency room visits and hospitalizations by decreasing the number of overdoses; and

Whereas, syringe service programs are cost-effective for the taxpayer, and for every $1 spent on the program, up to $7.58 is saved in HIV treatment costs; and

Whereas, the patrons of syringe service programs are often mobile and without permanent housing, and by limiting the program within geographic boundaries, we are limiting participation and increasing the spread of disease; and

Whereas, additional support services are critical to the participants in the syringe service program; and

Whereas, the syringe service program is not the single solution to the substance use disorder epidemic but a component of a multi-pronged approach including prevention, treatment, and potentially criminal justice and social welfare; therefore, be it

RESOLVED, that ISMA seek legislative action for a statewide syringe service program under the auspices of the Indiana State Department of Health.

**RESOLUTION 19-17 DOCTOR-PATIENT RELATIONSHIP**

Introduced by: Linda Feiwell Abels, MD; and the Indianapolis Medical Society

Referred to: REFERENCE COMMITTEE 2

Whereas, the doctor-patient relationship is an integral part of health care and the practice of medicine; and

Whereas, the doctor-patient relationship forms one of the foundations of contemporary medicine; and

Whereas, the doctor-patient relationship can have a significant impact on health care outcomes; and

Whereas, the existence of the doctor-patient relationship, once established, imposes professional, ethical and legal obligations and duties on medical providers with respect to communication with patients; and

Whereas, all organizations have an ethical responsibility to be transparent with their consumers/patients regarding any policies or restrictions that may prohibit them from eroding the doctor-patient relationship; therefore, be it

RESOLVED, that ISMA seek legislation to ensure that existing practices notify patients when their physician changes location or provide patients with adequate information to access their physician upon request; and be it further

RESOLVED, that ISMA seek legislation that includes a requirement for physician approval on communication sent to patients by their previous practice.

**RESOLUTION 19-18 ISMA POLICY REGARDING MAINTENANCE OF CERTIFICATION (MOC)**

Introduced by: Don Selzer, MD

Referred to: REFERENCE COMMITTEE 1

Whereas, the ISMA House of Delegates (HOD) referred Resolution 16-46 to the Board of Trustees for study; and

Whereas, subsequently, the ISMA Commission on Legislation directed ISMA to support legislation, SB 203 (2018) and SB 208 (2019), prohibiting hospitals and insurance companies from instituting maintenance of certification (MOC) as the sole criteria for reimbursement or hospital staff or admitting privileges; and

Whereas, the American College of Physicians (ACP) strongly supports “the value of continuing certification programs”; and

Whereas, the ACP strongly supports “a new model of continuing certification”; and

Whereas, the ACP strongly supports “assessment models” that support lifelong learning; and

Whereas, the American Board of Internal Medicine (ABIM) has implemented a two-year Knowledge Check-In Program as an alternative to the MOC exam every 10 years; and

Whereas, the American Academy of Family Physicians (AAFP) is conducting a pilot of the Family Medicine Certification Longitudinal Assessment (FMCLA) as an alternative to the 10-year certification exam; and

Whereas, patients expect that their physician’s certification reflects ongoing education and improvement; and

Whereas, hospital and health system leadership recognize that diagnostic and treatment knowledge changes rapidly, and they value the competencies for medical practice set by the professions; and

Whereas, achieving and maintaining board certification is indicative of a physician’s personal commitment to providing quality patient care, and as mid-level providers lobby for independence, physicians must not lower the bar in regard to the professionalism of medicine; and

Whereas, in the 2018 Indiana legislative session, ISMA supported Senate Bill 208, which did not pass; and

Whereas, in the 2019 Indiana legislative session, ISMA supported a virtually identical Senate Bill 203, which did not pass; and

Whereas, “Legislation prohibiting hospitals and insurers from considering MOC as the sole criteria for reimbursement and hospital staff or admitting privileges interferes with the right of the profession to set its own standards interferes with the ability of insurers and hospital medical staffs to set their own quality standards and denies patients the right to know whether the physician caring for them is up to date in their field”; therefore, be it

RESOLVED, that ISMA remain neutral in the future regarding maintenance of certification legislation that prohibits hospitals and insurance companies from instituting MOC as the sole criteria for reimbursement, or hospital staff or admitting privileges, similar to SB 208 (2018) and SB 203 (2019).

**RESOLUTION 19-19 SPECIAL ELECTIONS FOR DISTRICT OFFICER VACANCIES**

Introduced by: J. Elizabeth Struble, MD, Chair of ISMA Board of Trustees

Referred to: REFERENCE COMMITTEE 1

Whereas, the ISMA Bylaws require that all ISMA districts host an annual district meeting in order to conduct elections for district leadership positions; and

Whereas, there have been occasions over the years where district elections have not been able to occur due to extenuating circumstances, such as severe weather or, as in 2019, the inability to obtain confirmation of a prospective candidate’s willingness to serve due to absence or the need for additional information; and

Whereas, these extenuating circumstances have resulted in one or more vacancies in district officer positions, including in 2019; and

Whereas, the current process under the ISMA Bylaws for electing district officers outside of the district meeting setting requires holding an additional in-person business meeting; and

Whereas, a special election conducted through electronic voting would provide a more streamlined and efficient process for electing district officers when vacancies occur; therefore, be it

RESOLVED, that the ISMA Bylaws be modernized to allow district officer vacancies to be filled where those vacancies exist due to extenuating circumstances by holding special elections conducted through electronic voting, as follows:

**5.03 ELECTION - TRUSTEE AND ALTERNATE**

The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive Vice President of the Association shall ~~cause~~ call for a special ~~meeting~~ election to be ~~called~~ held by said district society as set forth in 5.05 for the purpose of such election.

**5.05 VACANCIES**

In the event of a vacancy occurring from any cause, except expiration of the term of office in the office of a district trustee, the duly elected alternate trustee from the same district shall temporarily assume, on an interim basis, the office of the trustee in that district, until such time as the vacancy is filled by election. In the event of a vacancy in the office of the alternate trustee, the president of the district medical society shall temporarily assume, on an interim basis, the office of alternate trustee until such time as the alternate trustee can resume the duties of that office, or until such time as a new alternate trustee is elected.

If, due to extenuating circumstances, an annual district meeting does not occur or a vacancy remains ~~In the event vacancies occur~~ in any trustee district in the offices of either the trustee or alternate trustee, the vacancies shall be filled on a permanent basis by a~~n~~ special election by the members of the association within the trustee district in which the vacancies occur. A call for such special election~~s~~ shall be issued electronically by the Executive Vice President of the Indiana State Medical Association following a conference(s) with the officers of the district organization. The call shall also be issued following the circulation of an electronic notice to each member within the district stating that a vacancy exists and soliciting nominations for the vacancy. The notice shall also include the deadline for nominating a member for the vacancy, which shall not be less than two (2) weeks from the date the notice is circulated to each member within the district. The subsequent call for the special election shall state the purpose of the special ~~date, time and place of holding the~~ election and shall provide a means by which each member within the district can electronically cast a vote for any nominated candidate for the existing vacancy. The call shall also include the deadline for casting a vote, which shall not be less than two (2) weeks from the date the call is circulated. The electronic notice and call shall be sent to the e-mail address then appearing on the records of the Association for each member of each component society within the district. A majority of the votes cast shall be necessary to elect.~~registered mail to the county secretary, as filed in the Indiana State Medical Association Executive Vice President's office, of each component society within the district. Such call shall be mailed within ten days after the Executive Vice President of ISMA has learned of the vacancies. The election may be held at a regular meeting at which business other than the election may be transacted. Such election shall be within 15 days after the Executive Vice President of the Indiana State Medical Association shall have mailed such call.~~ If an alternate trustee is elected as trustee in such an election, the resultant vacancy in the position of alternate trustee may be filled by holding another special election ~~immediately by election at the same meeting, without further notice~~.

**13.04 OFFICERS**

Each district society shall organize by electing a President, a Secretary and a Treasurer and Trustee(s) and Alternate Trustee(s) as the current Trustee(s) term and Alternate Trustee(s) term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The offices of Secretary and Treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association. If any district fails to meet and elect a President by the expiration of the incumbent’s term of office, the Executive Vice President of the Association shall send notice and a call for a special election to be held by said district society as set forth in 5.05 for the purpose of such election.

13.0801 **Election of Trustee or Alternate**

Except in the case of a special election as set forth in 5.05, whenever a district society is to elect a Trustee and/or Alternate, the headquarters office of the Indiana State Medical Association shall so notify the individual members of such district society not later than six weeks in advance of said election date.

**RESOLUTION 19-20 FAA REQUIREMENTS FOR IN-FLIGHT EMERGENCY MEDICAL KITS (EMK)**

Introduced by: Heidi M. Dunniway, MD; and the Vanderburgh County Medical Society

Referred to: REFERENCE COMMITTEE 4

Whereas, an estimated 1.6% to 5.1% of Americans have experienced anaphylaxis, and it is estimated that there is one death for every 200 episodes of anaphylaxis; and

Whereas, delayed administration of epinephrine increases the risk of death from anaphylaxis; and

Whereas, it is estimated that up to 8% of adults in the U.S. suffer from substance use disorder (SUD), and the U.S. rate of death from drug overdose, primarily related to synthetic opiates other than methadone, increased 12.9-fold between 2007 and 2017; and

Whereas, immediate availability of naloxone or other opioid antagonists is necessary to prevent death from opioid overdose; and

Whereas, since 1986, the Federal Aviation Administration (FAA) has required automated external defibrillators (AEDs) and emergency medical kits (EMKs) on all flights with a capacity of 30 passengers or requiring at least one flight attendant; and

Whereas, the FAA last updated required contents for EMKs in 2006; and

Whereas, EMKs are sealed, with no requirement for external visibility of content expiration dates, and current requirements dictate assessment expiration dates annually; and

Whereas, among the required contents of EMKs are two vials each of 1cc epinephrine 1:1000 and 2 cc epinephrine 1;10,000, needles and syringes, along with basic instructions for use of the medications; and

Whereas, epinephrine autoinjectors make the administration of epinephrine straightforward for individuals, including aircrew, with limited medical training, and the need to draw up and inject the epinephrine has the potential to cause a critical delay in the necessary, immediate treatment of in-flight anaphylaxis; and

Whereas, naloxone is available for intranasal administration, and an opioid antagonist, such as naloxone, is not currently a required element in the EMKs; therefore, be it

RESOLVED, that ISMA support review of emergency medical kit (EMK) contents by the Federal Aviation Administration (FAA), with the addition of appropriate quantities of epinephrine autoinjectors and an opioid antagonist, such as naloxone, to required EMK contents and with further review of the contents at defined intervals; and be it further

RESOLVED, that ISMA support readily visible external labeling of sealed EMKs to include expiration dates of injectable medications and fluids and review of each kit’s medication expiration dates as labeled more frequently than annually; and be it further

RESOLVED, that ISMA ask the AMA to work with the FAA for the following purposes:

* Reviewing and updating of the required EMK contents, with inclusion of appropriate quantities of epinephrine autoinjectors in the EMK and an opioid antagonist, such as naloxone, and with subsequent review and update of EMK contents at defined intervals
* Requiring readily visible, external labeling of EMKs to include expiration dates of injectable medications and IV fluids
* Requiring review of each kit’s medication expiration dates as labeled more frequently than annually

**References**

1. Allergy Clin Immunol Pract 2017; 5:1169-78.
2. <https://www.sihd.nsw.gov.au-allergy>
3. <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>
4. FAA Advisory Circular, *Emergency Medical Equipment*; January 12, 2006. AC No 121-33B.

**RESOLUTION 19-21 EMERGENCY MEDICAL TRANSPORTATION OF INCAPACITATED PATIENTS**

Introduced by: Kimberly Chernoby, MD, JD; and Mark Liao, MD

Referred to: REFERENCE COMMITTEE 3

Whereas, there are many conditions that render a patient incapacitated to make medical decisions; and

Whereas, incapacitated patients sometimes refuse medical care, including emergency transport to a health care facility, that patients with decision-making capacity would consent to; and   
  
Whereas, Indiana law only protects physicians and law enforcement when providing care to patients incapacitated for mental health reasons; and   
  
Whereas, New Mexico has successfully passed legislation that protects emergency medical technicians (EMTs) who transport patients they believe in good faith are incapacitated and require life- or limb-saving treatment; and

Whereas EMTs in Indiana are currently prohibited from transporting patients who are incapacitated and require life- or limb-threatening treatment unless that patient agrees to be transported; therefore, be it

RESOLVED, that ISMA seek legislation to protect emergency medical

technicians who transport patients who are judged, on the good faith

evaluation of the technician or in coordination with online medical direction,

to lack decision-making capacity and require transport to a health care

facility for life- or limb-saving treatment.

**RESOLUTION 19-22 DRUG PRICING TRANSPARENCY**

Introduced by: Thomas Vidic, MD

Referred to: REFERENCE COMMITTEE 3

Whereas, between 2013 and 2015, net spending on prescription medication increased by 20%1 and, in 2017, increased by $333.4 billion or 10% of total U.S. health care spending2; and

Whereas, an NPR survey conducted in June 2017 found that 33% of respondents who were prescribed medications by their physicians considered the cost before filling; of the 3% of respondents who did not fill or pick up the prescription at all, 67% did so because of cost; and of the 29% of respondents who have stopped taking a prescribed medication without telling their provider, 10.3% have done so because of cost3; and

Whereas, physicians are aware that drug costs have become a major barrier to patients but are unable to evaluate the costs of prescription drugs due to industry practices that include frequent changes to formularies and pharmacy benefits; utilization management mechanisms, such as prior authorization and step therapy; and burdensome documentation requirements4; and

Whereas, pharmacy benefit managers fully administer drug benefits for health care insurance plans, yet are not regulated in the same manner as insurers that provide similar services to customers6, 7; and

Whereas, there is evidence that rebates and concessions that are negotiated by pharmacy benefit managers and manufacturers result in list prices far above what they would be absent these incentives, but patients and other purchasers have no avenues for appeal, since these negotiations are proprietary and trade secrets8; and

Whereas, there has been tremendous interest in addressing drug pricing and drug price transparency from the Federal Executive,9 U.S. Congress,10, 11 the Indiana General Assembly,12 the American Medical Association,13 the Indiana State Medical Association,14 and grassroots organizations; and

Whereas, in response to significant pressure to address drug pricing and drug pricing transparency, the Indiana General Assembly introduced House Bills 1180, 1252 and 1029 in 2019, of which House Bill 1029 passed and was signed into law, assigning these issues for further study in committee over the summer leading into the 2020 legislative session15, 16, 17; and

Whereas, per Resolution 18-54, ISMA testified in support of Indiana House Bill 1180 (2019), advocating for state legislation to study drug pricing and to ultimately address drug pricing transparency; therefore, be it

RESOLVED, that ISMA support legislation providing that a patient who is established on a drug may remain on that drug within a plan year without a change in co-pay or formulary inclusion; and be it further

RESOLVED, that ISMA advocate for state legislation that requires greater reporting of drug prices and the reasons behind them by pharmacy benefit managers, pharmaceutical manufacturers, health care insurers and other relevant entities; and be it further

RESOLVED, that ISMA advocate for the state to create programs for disclosure of effective drug prices:

(1) to patients, such as through clear explanations of pharmacy benefits and reasonable limits on formulary changes;

(2) to physicians, such as through integration of pricing and formulary data in electronic medical record systems; and

(3) to other stakeholders, such as through establishment of an independent auditor who will verify and prepare drug pricing information to the state legislature and the public.

1 JAMA Internal Medicine, “Association of Prescription Drug Price Rebates in Medicare Part D With Patient Out-of-Pocket and Federal Spending”.

2 Center for Medicaid Services, “[National Health Expenditures 2017 Highlights](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf).”

3 National Public Radio, “[Health Poll: Prescription Drugs](http://truvenhealth.com/Portals/0/Assets/TRU_18156_0617_NPR_Poll_Prescription_Drugs_FINAL.pdf)”.

4 American Medical Association, [Letter in Response to “American Patients First”](https://searchlf.ama-assn.org/undefined/documentDownload?uri=/unstructured/binary/letter/LETTERS/2018-7-16-Letter-to-Azar-re-BluePrint-RFI.pdf).

5 CBS News, “[Feeling the pain of rising drug prices? Blame the middle man](https://www.cbsnews.com/news/drug-prices-rising-pharmacy-benefit-managers-middle-man/)”.

6 Indiana State House of Representatives, [House Bill 1180](http://iga.in.gov/legislative/2019/bills/house/1180#document-0331f8a0).

7 Indiana State House of Representatives, [House Bill 1252](http://iga.in.gov/legislative/2019/bills/house/1252).

8 JAMA Internal Medicine, “Association of Prescription Drug Price Rebates in Medicare Part D With Patient Out-of-Pocket and Federal Spending”.

9 U.S. Department of Health & Human Services, “[American Patients First](https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf)”.

10 U.S. Congress, [S.2553 – Know the Lowest Price Act of 2018](https://www.congress.gov/bill/115th-congress/senate-bill/2553?q=%7B%22search%22%3A%5B%22know+the+lowest+price+act%22%5D%7D&r=1)

11 U.S. Congress, [S.2554 – Patient Right to Know Drug Prices Act](https://www.congress.gov/bill/115th-congress/senate-bill/2553?q=%7B%22search%22%3A%5B%22know+the+lowest+price+act%22%5D%7D&r=1)

12 Indiana Code [5-10-8-20](http://iga.in.gov/legislative/laws/2018/ic/titles/005/#5-10-8-20) (Formerly HE 1317)

13 American Medical Association, [TruthInRx Campaign](https://truthinrx.org/).

14 Indiana State Medical Association, Resolution 18-54

15 Indiana State House of Representatives, [House Bill 1180](http://iga.in.gov/legislative/2019/bills/house/1180#document-0331f8a0).

16 Indiana State House of Representatives, [House Bill 1252](http://iga.in.gov/legislative/2019/bills/house/1252).

17 Indiana General Assembly, [House Enrolled Act No. 1029](http://iga.in.gov/legislative/2019/bills/house/1029#document-b21bb758).

18 American Medical Association, “An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases During the Plan Year.”

**RESOLUTION 19-23 DISSOLUTION OF ISMA GRIEVANCE COMMITTEE**

Introduced by: J. Elizabeth Struble, MD, Chair of ISMA Board of Trustees

Referred to: REFERENCE COMMITTEE 1

Whereas, the ISMA Bylaws currently include a Grievance Committee as one of the ISMA’s standing committees; and

Whereas, the stated purpose of the ISMA Grievance Committee is to receive complaints, appeals or suggestions from physicians or lay persons concerning professional conduct; and

Whereas, the Grievance Committee was expected to find the facts regarding matters brought to its attention and attempt to adjust differences between patients and physicians; and

Whereas, patients occasionally contact ISMA to complain about physicians; and

Whereas, some patient complaints involve misunderstandings regarding administrative issues and/or laws, such as termination from a practice or access to medical records, which can and have historically been addressed by ISMA staff without the need to formally convene a committee of physicians; and

Whereas, in contrast, the vast majority of patient complaints to ISMA involve patients who are seeking redress not within the capability or authority of the ISMA staff or the ISMA Grievance Committee, such as patients who seek a refund or a prescription; who request that the physician’s employment be terminated or license disciplined; or who wish to initiate a legal investigation; and

Whereas, for reasons such as those, the ISMA Grievance Committee has not convened in approximately 10 years; and

Whereas, it is unnecessary for the ISMA president to annually appoint members to a committee that no longer convenes; and

Whereas, ISMA Bylaws Section 5.0612 requires the ISMA Board of Trustees to determine if commissions and committees are “performing adequately, effectively, and efficiently” and, if not, permit the Board to recommend their dissolution to the House of Delegates; therefore, be it

RESOLVED, that the ISMA Grievance Committee be dissolved by amending the Bylaws to remove any reference to it, as follows:

~~7.010101~~ **~~Grievance~~**

~~7.1001 Grievance Committee~~

~~The duties of this committee shall be to receive complaints, appeals, or suggestions from physicians or lay persons concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians. It may, if it believes the facts justify, cite a member of the Indiana State Medical Association to the Board of the Indiana State Medical Association. It shall, subject to the approval of the Board, revise its set of rules and regulations governing its procedure and official actions.~~

**RESOLUTION 19-24 GRADUATE MEDICAL EDUCATION FUNDING**

Introduced by: Stacie Wenk, DO

Referred to: REFERENCE COMMITTEE 2

Whereas, Resolution 09-38 will expire in 2019 if not readopted; and

Whereas, residents contribute to the high quality of patient care for all of the citizens of Indiana, directly and indirectly; and

Whereas, the high educational standards in graduate medical education that have existed in Indiana require a sound financial base; and

Whereas, a decrease in the state funding will jeopardize medical education as well as the health care in Indiana; and

Whereas, the Indiana General Assembly passed House Bill 1323 in 2015, establishing a medical residency education fund (“Fund”) and a graduate medical education board (“Board”) to oversee its disbursement to programs not funded by the Centers for Medicare and Medicaid Services, and to new and expanding residency programs in need of financial and logistical assistance1; and

Whereas, to date, the Board has helped create 221 new residency positions in Indiana, including at Indiana University School of Medicine in Indianapolis, Fort Wayne Medical Education Program in Fort Wayne and Reid Health in Richmond2; and

Whereas, the Southwestern Indiana Graduate Medical Education Consortium in collaboration with the Board and Indiana University School of Medicine established a Psychiatry Residency for four residents annually at Good Samaritan Hospital in Vincennes3; a Family Medicine Residency Program for five residents at Memorial Hospital and Health Care Center in Jasper4; and an Internal Medicine Residency Program for 16 residents at Good Samaritan Hospital in Vincennes and Saint Vincent Hospital in Evansville5; and

Whereas, as of January 2019, the Board is working with 10 Indiana programs to study the feasibility of creating or expanding graduate medical residency programs; one program to further develop its plan to create a residency program; and six programs to fund and expand successfully implemented programs and expansions2; and

Whereas, in support of the Board’s efforts, the Indiana General Assembly has increased its allocations to the Fund to $8 million over fiscal years 2019-20216; and

Whereas, members of the Board have been approached by counterparts from other states hoping to learn from Indiana’s initiative7; and

Whereas, in 2016, there were only 387 available PGY-1 positions in Indiana, meaning many of the over 500 medical students graduating annually from Indiana medical schools must pursue residency training out-of-state despite a potential desire to remain in-state8; and

Whereas, the Board and Fund began only in 2015 and is funded on a biennial basis, but new and expanded medical residency programs must operate for at least five years before becoming eligible for federal support7; therefore, be it

RESOLVED, that ISMA readopt Resolution 09-38 as amended, as follows:

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

1 Indiana General Assembly, [House Bill 1323 of 2015 (Public Law 190)](http://iga.in.gov/legislative/2015/bills/house/1323).

2 Graduate Medical Education Board, [“Indiana Graduate Medical Residency Program: Meeting State Need for More Quality Primary Care Physicians.”](https://www.in.gov/che/files/Indiana%20GME%20Expansion%20Plan_2019_UPDATED.pdf)

3 WAMW News, “[Good Samaritan to welcome 4 psychiatry residents.](https://www.wamwamfm.com/2019/06/20/good-samaritan-to-welcome-4-psychiatry-residents/)”

4 WJTS News, “[Memorial Hospital Announces New Family Medicine Residents.](http://wjts.tv/2019/03/memorial-hospital-announces-new-family-medicine-residents/)”

5 Indiana University School of Medicine, “[Indiana University School of Medicine Southwest Indiana Internal Medicine Residency receives accreditation.](https://medicine.iu.edu/news/2019/04/indiana-university-school-of-medicine-southwest-indiana-internal-medicine-residency-receives-accreditation/)”

6 Indiana General Assembly, [House Enrolled Act 1001 of 2019](https://www.in.gov/sba/files/AP_2019_0_0_0_0_HEA_1001_-_The_Budget_Bill.pdf).

7 Graduate Medical Education Board, [Meeting Minutes – January 10, 2019](https://www.in.gov/che/files/Indiana_GME_Board_1_10_19_Meeting_Minutes%20(final).pdf).

8 Graduate Medical Education Board, [“Cultivating the Physicians of the Future through Targeted Funding Initiatives.”](https://www.in.gov/che/files/Tripp%20Umbach%20Indiana%20GME%20Report%20Summary.pdf)

**RESOLUTION 19-25 TOBACCO SETTLEMENT**

Introduced by: Stacie Wenk, DO

Referred to: REFERENCE COMMITTEE 4

Whereas, Resolution 09-13 is set to expire in 2019 if not readopted; and

Whereas, it is well documented that abuse of tobacco has had a very detrimental effect on the health and well-being of Indiana citizens and smoking is the leading cause of preventable disease and death in the United States[[18]](#footnote-18); and

Whereas, in November 1998, 46 state Attorneys General and the tobacco industry settled pending litigation that resulted in the Master Tobacco Settlement Agreement (“Settlement”)[[19]](#footnote-19); and

Whereas, under the Settlement, Indiana has generally received 2.039% of the Settlement in the form of annual payments[[20]](#footnote-20); and

Whereas, in 1999, the Indiana General Assembly created the Tobacco Master Settlement Fund (“Fund”) to house Indiana’s share of the Settlement[[21]](#footnote-21); and

Whereas, the payments received from the Settlement have resulted in an average of approximately $130 million being deposited into the Fund on an annual basis in recent years[[22]](#footnote-22); and

Whereas, Indiana spent approximately $7.5 million in FY2018 on state tobacco prevention programs, compared with the CDC recommendation of $73.5 million per year[[23]](#footnote-23); and

Whereas, some of the monies in the Fund are allocated toward initiatives that do not directly benefit the health and well-being of Indiana citizens[[24]](#footnote-24); and

Whereas, Indiana ranked 48th in public health funding in the United States in 2018 and among the worst in every health metric[[25]](#footnote-25); and

Whereas, physicians are in the best position to know the health care needs of our patients and our communities; therefore, be it

RESOLVED, that the ISMA readopt Resolution 09-13 as amended, as follows:

RESOLVED, that ISMA declare as policy that all monies derived from the ~~“tobacco settlement”~~ Master Tobacco Settlement Agreement and deposited into the Indiana Tobacco Master Settlement Fund be used for health care and the promotion of community health; and be it further

RESOLVED, that ISMA continue to take a leadership role with all other health care entities to ensure that ~~“tobacco settlement”~~ monies in the Indiana Tobacco Master Settlement Fund remain completely and totally within the health care arena.~~; and be it further~~

~~RESOLVED, that ISMA seek or support legislation that would establish a nonprofit, independent health endowment foundation or board outside the influence of the tobacco industry to administer a significant percentage of “tobacco settlement” funds for tobacco control, health, public health and research activities.~~

**RESOLUTION 19-26 PROHIBITING UNLICENSED MIDWIFERY**

Introduced by: Rhonda L. Sharp, MD

Referred to: REFERENCE COMMITTEE 4

Whereas, Resolution 09-33 will expire in 2019 if not readopted; and

Whereas, under Indiana law, individuals may not engage in the practice of midwifery without first obtaining a certified nurse midwife license[[26]](#footnote-26) or a certified direct entry midwife certificate[[27]](#footnote-27); and

Whereas, it continues to be illegal in Indiana to practice lay midwifery without the appropriate licensure or certification; and

Whereas, lay midwifery continues to be a problem Indiana[[28]](#footnote-28); therefore, be it

RESOLVED, that the ISMA readopt Resolution 09-33 as amended, as follows:

RESOLVED, that the ISMA support continued ~~recommend~~ enforcement of existing laws that prohibit midwifery by unlicensed or uncertified individuals.

**RESOLUTION 19-27 HEALTH REFORM PRINCIPLES**

Introduced by: Stephen Tharp, MD

Referred to: REFERENCE COMMITTEE 3

Whereas, Resolution 09-67 is set to expire in 2019 if not readopted; and

Whereas, numerous proposals and principles for national health reform continue to be discussed; and

Whereas, in order to assist ISMA in participating in the national health reform discussion, it would be useful for ISMA members to maintain a framework of health reform principles that ISMA supports; therefore, be it

RESOLVED, that ISMA readopt Resolution 09-67 as amended, as follows:

~~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 ISMA support~~s~~ the following principles regarding health care reform:

* 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.

**RESOLUTION 19-28 USE OF TERM “PROVIDER”**

Introduced by: Stacie Wenk, DO

Referred to: REFERENCE COMMITTEE 3

Whereas, Resolution 09-59 will expire in 2019 unless readopted; and

Whereas, the word “provider” does not define “physician” adequately and is commonly used to refer to nonphysicians; and

Whereas, physicians and other health care providers have different training, expertise and qualifications; and

Whereas, laypersons (patients) think a “provider” is a physician when, in fact, many providers are not physicians; therefore, be it

RESOLVED, that ISMA readopt Resolution 09-59 as amended, as follows:

RESOLVED, that ISMA oppose the use of the term “provider” or “health care provider” to refer to a physician.~~; and be it further~~

~~RESOLVED, that our delegates to the AMA pursue remedies on a national level to correct this misuse of these terms.~~

**RESOLUTION 19-29 NON-PHYSICIAN DIAGNOSIS**

Introduced by: Stacie Wenk, DO

Referred to: REFERENCE COMMITTEE 2

Whereas, Resolution 09-50 will expire in 2019 if not readopted; and

Whereas, certain allied health professionals continue to seek expansion of their respective scopes of practice; therefore, be it

RESOLVED, that ISMA readopt Resolution 09-50 as follows:

RESOLVED, that 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 19-30 HOSPITAL DELIVERIES**

Introduced by: Rhonda L. Sharp, MD

Referred to: REFERENCE COMMITTEE 4

Whereas, Resolution 09-28 is set to expire in 2019 if not readopted; and

Whereas, home deliveries will likely result in higher maternal and fetal morbidity and mortality; and

Whereas, the Indiana State Medical Association has traditionally discouraged practices known to be detrimental to the health and safety of mothers and newborn babies, as well as that of the public generally; therefore, be it

RESOLVED, that ISMA readopt Resolution 09-28 as follows:

RESOLVED, that 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 19-31 VIRTUAL ANNUAL MEETING ATTENDANCE USING NEW TECHNOLOGY**

Introduced by: Deepak Azad, MD; and Kevin Burke, MD

Referred to: REFERENCE COMMITTEE 1

Whereas, the ISMA House of Delegates previously considered Resolution 13-31, which would have allowed for virtual attendance of ISMA’s annual convention. The resolution was referred to the Board of Trustees for Action and the Board formed a Task Force, appointed by ISMA President Dr. Deepak Azad. After study, they elected not to proceed due to concerns about the logistics, practicality and cost of such a proposal at that time; and

Whereas, physicians as a whole now are much more familiar with virtual technology and even themselves have furthered telemedicine using virtual technology; and

Whereas, costs have fallen, with technology and software now being much more sophisticated and interactive and providing a virtual experience that rivals reality; and

Whereas, governments and business are increasingly using virtual communication as a most effective way to function; and

Whereas, younger physicians are probably more likely to cite the difficulties that come with attending multiday meetings, while they are usually more comfortable than older physicians with virtual technology and therefore may be more likely to attend a meeting if given two choices; and

Whereas, physicians could attend the meeting in part in person and in part virtually; and

Whereas, lower membership and lower participation numbers will diminish the association’s ability to advocate for patients and physicians; therefore, be it

RESOLVED, that the ISMA Board of Trustees appoint a committee to look at the cost and logistics of offering virtual attendance at the ISMA annual convention, which study shall include polling medical associations that have successfully established virtual annual meetings. The committee shall issue its report to the association president and Board of Trustees for their consideration.

**RESOLUTION 19-32 ISSUES WITH THE MATCH, THE NATIONAL RESIDENCY MATCHING PROGRAM (NRMP)**

Introduced by: Deepak Azad, MD; and Kevin Burke, MD

Referred to: REFERENCE COMMITTEE 3

Whereas, a record number of physicians applied for residency programs through The Match in 2019. The total was 44,603 with ultimately 2718 withdrawing and 3509 not fully completing the application process. Of the remainder who went through the Match program, only 79.6% of 38,376 matched, with 7826 unmatched; and

Whereas, applicants who do not match the first time very quickly go through a secondary match called the SOAP (Supplemental Offer and Acceptance Program); and

Whereas, there continues to be a growing discrepancy between the number of medical school graduates and the available residency spots, such that the number of applicants who do not match each year is growing. This is occurring during a time that is characterized by a growing shortage of physicians with a large number of over-60-year-old doctors who will be retiring within the next 10 years; and

Whereas, medical school graduates typically incur a significant burden of academic loans through their years of education. This burden is worsened by the fees charged to go through The Match process, with the cost ranging from $85 up to thousands of dollars. The residency programs also pay The Match for their services, which range from $370 up to many thousands of dollars. The income generated by the match has become quite lucrative as the number of applicants grows from year to year. The Board of the National Residency Matching Program (BNRMP) has an obligation to be good stewards of these funds and to ensure that are spent wisely and frugally; and

Whereas, the SOAP gives applicants who fail to match in the first round an opportunity to find a position in a second-round matching process. This year, the SOAP website crashed on the first day that it came online, such that participants could not enter their program of choice and the programs could not see the list of those interested in a residency spot. The board extended the SOAP one additional day in order to accommodate those who were not well served. Undoubtedly, this system failure affected the outcome of the secondary match for some individuals in a negative way and others in a positive way. In other words, changing the procedure and process of the SOAP produced a different outcome than if the system had not failed; and

Whereas, failing to match initially is an extremely stressful and difficult time as applicants try to learn about the residencies that have remaining spots. The stress and worry become orders of magnitude greater if applicants do not match under the SOAP as they scramble to sort out what they will do with their lives during the next year, when they typically apply again through the program. They also worry about what issue or issues contributed to their failure to match; and

Whereas, it is enough of a problem to fail to match for one year, but it is a tragedy to have expended the blood, sweat, tears and money to become a physician and yet never match. This is also a tremendous waste of taxpayer dollars, since these individuals can never independently practice as physicians and yet the state and nation have invested hundreds of thousands of dollars in their education; therefore, be it

RESOLVED, that ISMA encourage the American Medical Association (AMA) to redouble its efforts to promote an increase in residency program positions in the U.S.; and be it further

RESOLVED, that the ISMA (HOD (House of Delegates) ask the AMA (American Medical Association) HOD to assign appropriate AMA committee or committees to:

* Study the issue of why the residency positions have not kept pace with the new physician supply and also investigate what novel residency programs have been successfully developed across the country in order to expand positions using both traditional and nontraditional mechanisms.
* Seek to determine what causes a failure to Match and better understand what strategies are most effective in increasing the chances of a successful Match especially after a prior failure to Match. The committee(s) would depend upon the BNRMP (Board of the National Residency Matching Program) to provide some of this information through surveys, questionnaires and other means. If valid statistics are gleaned, then this information would be of value to medical students who seek to improve their chances of success in The Match.
* Investigate the assistant physician programs that are now operating in several states as an alternative way for physicians to gain clinical experience and to hopefully improve their chances of eventually obtaining an unrestricted medical license and to understand how practical and successful they are.
* Report back to the AMA and ISMA HOD with their findings and recommendations; and be it further

RESOLVED, because SOAP (Supplemental Offer and Acceptance Program) failed to adequately serve some physicians seeking to Match this year, the ISMA HOD ask the AMA House of Delegates to support the suggestion that those individuals would be offered the option of participating in one future Match at no charge; and be it further

RESOLVED, in order to understand the cost of The Match and to identify possible savings, the ISMA HOD asks the AMA House of Delegates to request that the Board of the National Residency Matching Program undergo an independent and fully transparent audit with identification of opportunities for savings, with the goal of lowering the financial burden on medical students and new physicians. It is expected that the BNRMP would avail itself of these opportunities; and be it further

RESOLVED, the ISMA HOD ask the AMA HOD to encourage the Board of the National Residency Matching Program to propagate the lessons learned from the AMA committee(s) work, such that it would actively promote success for those participating in The Match by better understanding and identifying those issues that interfere with the successful Match and to identify strategies to mitigate those issues. This important knowledge can be disseminated through the program website and through its services such as its “help” and “Q&A” links, and also through the AMA.

**RESOLUTION 19-33 PREVENTING NEONATAL ABSTINENCE SYNDROME**

Introduced by: Deepak Azad, MD; and Kevin Burke, MD

Referred to: REFERENCE COMMITTEE 4

Whereas, the use of opioids, both legal and illegal, is growing in most Indiana counties. The most commonly used form is methadone; and

Whereas, Indiana hospitals are dealing increasingly with neonatal abstinence syndrome in babies exposed in utero to legal and illegal opioids; and

Whereas, the neonatal abstinence syndrome causes increased infant mortality, seizures, pain and agitation and is associated with hospital stays lasting days to weeks, with medical costs in the tens of thousands of dollars; and

Whereas, Indiana hospitals that treat these individuals have had to expand their facilities and staff in order to be capable of treating neonatal abstinence syndrome; and

Whereas, the best way to avert the suffering of neonates and distressed mothers is to prevent pregnancy by using contraception. Almost half the people in these programs are female and a significant number are fertile and not on birth control; therefore, be it

RESOLVED, that ISMA seek a rule or legislation that mandates that opioid facilities provide routine gynecologic care, including long-term contraception, or to have a referral agreement with an alternate facility that provides such services.

**RESOLUTION 19-34 FINANCIAL BURDEN OF USMLE STEP 2 CS ON MEDICAL STUDENTS**

Introduced by: Deepak Azad, MD; and Kevin Burke, MD

Referred to: REFERENCE COMMITTEE 3

Whereas, the cost of medical education and testing is rising, with no relief in sight for medical students; and

Whereas, the cost of USMLE Step 2 CS Exam will be $1,300 in 2020[[29]](#footnote-29) and most medical students will have to travel and stay near one of the five national testing centers; and

Whereas, the USMLE Step 2 CS Exam costs approximately $27.5 million annually and nationally to medical students, not including travel expenses[[30]](#footnote-30); and

Whereas, it should be noted that there is no good correlation between Board certification and physician competency; and

Whereas, there are no data to support a link between the USMLE Step 2 CS Exam and improved patient outcomes and 95% of U.S. medical students pass on their first attempt[[31]](#footnote-31); therefore, be it

RESOLVED, that ISMA and the AMA ask USMLE to reduce the cost of the USMLE Step 2 CS exam and allow medical students to take this exam locally to help avoid unnecessary expenses; and be it further

RESOLVED, that ISMA ask the AMA to study which of the national tests is valid and useful in assessing medical student competency, medical knowledge and U.S. medical education.

**RESOLUTION 19-35 PROTECTING SENIORS FROM MEDICARE ADVANTAGE PLANS**

Introduced by: Deepak Azad, MD; and Kevin Burke, MD

Referred to: REFERENCE COMMITTEE 2

Whereas, Medicare Advantage plans are heavily marketed to seniors by insurance companies, with less than ideal transparency in advertising; and  
  
Whereas, these plans produce higher insurance company profits at cost to CMS because Advantage plans are paid at a higher rate than traditional Medicare; and  
  
Whereas, there also is a potential for higher annual and lifetime costs paid by the patient under an Advantage Plans; and  
  
Whereas, presentations by insurance company officials to seniors can overemphasize the value on different options and can create confusion; therefore, be it  
  
RESOLVED, that ISMA ask the state attorney general and/or insurance commissioner to scrutinize Advantage plan insurance companies closely for accuracy in their advertisements and clarity of their presentation to seniors and their family members; and be it further

RESOLVED, that ISMA ask the AMA, AARP, insurance companies and other vested parties to develop guidelines on how to compare and contrast Advantage Plan policies; and be it further

RESOLVED, that ISMA and the AMA expect all insurance companies to operate under highest ethical standards.

**RESOLUTION 19-36 CONTRACEPTION COUNSELING FOR INCARCERATED FEMALES**

Introduced by: Deepak Azad, MD; and Kevin Burke, MD

Referred to: REFERENCE COMMITTEE 4  
  
Whereas, more than 110,000 women were in federal and state prisons in the U.S. at the year end of 2016, with 75% of this remain being 18 to 44 years old and in reproductive age; and  
  
Whereas, the number of incarcerated women increased by more than 750% between 1980 and 2017; and  
  
Whereas, in Indiana, female incarceration rate is 71/100,000; and

Whereas, in spite of security and monitoring systems, sexual activity does occur in prison. and contraception counseling should be offered to this prison population; and

Whereas, these individuals have committed serious crimes but they still have the right to protect themselves against unplanned pregnancy; therefore, be it

RESOLVED, that ISMA support legislation to provide counseling and contraception to females in Indiana correctional facilities.   
  
References:  
<https://www.jailcare.org/>  
  
<https://www.hopkinsmedicine.org/news/newsroom/news-releases/first-of-its-kind-statistics-on-pregnant-women-in-us-prisons>  
  
<https://journalofethics.ama-assn.org/article/shackling-and-separation-motherhood-prison/2013-09>

**RESOLUTION 19-37 OPPOSE GOVERNMENT INTERVENTION INTO RESTRICTING THE SCOPE OF FAMILY PLANNING TRAINING**

Introduced by: Alison Case, MD; and Kathryn Carboneau, MD

Referred to: REFERENCE COMMITTEE 2

Whereas, many women’s health professional organizations have stated the importance of access to comprehensive reproductive health care, including abortion, as essential for women’s health[[32]](#footnote-32); and

Whereas, reproductive health care is an essential component of obstetrics and gynecology, family medicine, adolescent health and public health training[[33]](#footnote-33); and

Whereas, the American College of Obstetricians and Gynecologists supports universal opt-out abortion training opportunities[[34]](#footnote-34); and

Whereas, there is a shortage nationally of training experiences for medical students and residents interested in abortion care[[35]](#footnote-35); and

Whereas, ISMA opposes legislation that restricts access to abortion[[36]](#footnote-36); therefore, be it

RESOLVED, that ISMA oppose any government intervention into defining the scope of residency programs in Indiana, particularly with regard to reproductive health training; and be it further

RESOLVED, that ISMA support access to reproductive health training on an opt-out basis for residents.

**RESOLUTION 19-38 OPPOSE THE CRIMINALIZATION OF SELF-INDUCED ABORTION**

Introduced by: Alison Case, MD; and Kathryn Carboneau, MD

Referred to: REFERENCE COMMITTEE 4

Whereas, barriers to abortion care are widespread and multifactorial, including but not limited to: lack of access to clinics or providers, limited clinic capacity, the need for multiple appointments, state-imposed waiting periods, lack of insurance coverage, cost, gestational age limits, parental notification laws, stigma and misinformation[[37]](#footnote-37); and

Whereas, from the beginning of 2011 through July 2016, states enacted 334 new legal restrictions on abortion, further limiting access to abortion care. In 2018 alone, 695 provisions have already been introduced to further restrict abortion[[38]](#footnote-38); and

Whereas, these barriers are some of the many factors that cause patients to consider self-induced abortion. In 2015, there were more than 700,000 Google searches for information regarding self-induced abortion in the United States, suggesting that many patients consider this option. National studies of abortion patients have shown that approximately 2% of patients attempted to self-induce an abortion at some point in their lives. That number is higher in states such as Texas with stricter legal restrictions on abortion, where one study showed that 7% of patients attempted some method to end their pregnancy before presenting to the clinic[[39]](#footnote-39); and

Whereas, laws criminalizing self-induced abortion increase health risks and deter patients from seeking necessary health care services related to self-induced abortion or miscarriage[[40]](#footnote-40); and

Whereas, laws criminalizing patients who self-induce abortion lead to increased suspicion toward patients presenting to health care providers for miscarriage[[41]](#footnote-41); and

Whereas, the Academy of Obstetricians and Gynecologists (ACOG) has taken a very strong position that patients should not be prosecuted for trying to end their own pregnancies. Additionally, ACOG opposes forcing physicians to share information about patients due to its burdensome interference in the patient-provider relationship[[42]](#footnote-42); and

Whereas, the ability and willingness to access medical care if complications relating to self-induced abortion arise is essential for patient safety[[43]](#footnote-43); and

Whereas, the reproductive decision-making within the context of race, class and income status is experienced uniquely by all women, and women of color in particular. Women of color are more likely to be targeted for prosecution and investigation of self-induced abortion, due to disproportionate law enforcement of African American communities in general. Fear of prosecution and potential incarceration undermines public health endorsement of open communication with primary care providers, as well as promotion of early fetal-maternal care[[44]](#footnote-44) [[45]](#footnote-45); therefore, be it

RESOLVED, that ISMA lobby against any legislative efforts to criminalize self-induced abortion.

**LATE RESOLUTION 19-01 MEDICAL CANNABIS**

Introduced by: Clark Brittain, DO

Referred to: REFERENCE COMMITTEE 4

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

Whereas, to relieve this pain and suffering, 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 prompted physicians to call for a ban of these products because the therapeutic benefits outweigh the risks; and

Whereas, in contrast, cannabis has not been shown to cause any use-related deaths, and compared to medications used on a daily basis with patients, has few adverse side effects; and

Whereas, the medical use of cannabis 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 at the Institute of Medicine (IOM) reviewed scientific evidence assessing the risks and benefits of marijuana. (They concluded cannabis has therapeutic properties that can treat many illnesses and conditions. They further noted that "...Adverse side effects of marijuana (cannabis) use are within the range of effects for other medications." Some of these uses include treatment for HIV wasting, glaucoma, neurologic movement disorders and analgesia and antiemetic effect for some cancer patients); and

Whereas, more recently, the Institute of Medicine (IOM) has reviewed 10,000 scientific research papers regarding the use of cannabis in medicine and determined that cannabis has usefulness and safety for treating pain, some movement disorders and nausea induced by chemotherapy and wasting disorders; and

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

Whereas, we should not ignore any potentially effective and safe therapeutic option for patients because of its association with the illegal street drug use (any more than we do for many other drugs that we prescribe that can also be abused, such as morphine, codeine, hydrocodone, Duragesic and OxyContin); and

Whereas, there are now 33 states in the U.S., plus the District of Columbia, and four (out of five) permanently inhabited U.S. territories that allow medical cannabis for their residents, two states have CBD (Charlotte’s web equivalent) laws, and 22 states now have decriminalization laws for cannabis (in an effort at harm reduction and decreasing the prison population), and eight states have legalized cannabis for recreational use, as has Washington, D.C., and three states surrounding Indiana offer medical cannabis legally; and

Whereas, Indiana currently also allows CBD oil with limited THC; and

Whereas, in the states where medical cannabis is legal, there has been a significant reduction in narcotic drug overdose deaths; and

Whereas, the United States Justice Department has decided not to prosecute criminal charges for possession or use of medical marijuana in states where it has been legalized by the state government; and

Whereas, the Indiana State Medical Association has previously agreed to study and act on prior resolutions and failed to do so; and

Whereas, the Indiana state legislature has heard proposals to decriminalize cannabis and make it available medically but has yet to act on these proposals; therefore, be it

RESOLVED, that ISMA join the American College of Physicians (ACP) and the Institute of Medicine (IOM) and many other organizations in encouraging legislation to allow Indiana licensed physicians to legally recommend medical cannabis to patients suffering approved medical conditions where, in their medical judgment, it is the best therapeutic option for the patient. Specifically, we request the Indiana legislature to provide a legislative mechanism for the production and distribution of cannabis for medical purposes. Such legislation would optimally provide legal means such as a medical necessity defense to protect against prosecution of patients or physicians. This would in no way be supporting its legalization for general use, outside of medical practice.

# LATE RESOLUTION 19-02 RESTRICTION OF ASSAULT-TYPE WEAPONS

# Introduced by: Megan Chiu, Brandon Francis, Abigail Parker and Raveen Sugantharaj, ISMA- MSS

# Referred to: REFERENCE COMMITTEE 4

Whereas, Meriam-Webster Dictionary defines an assault rifle as “any of various intermediate-range, magazine-fed military rifles (such as the [AK-47](https://www.merriam-webster.com/dictionary/AK-47)) that can be set for automatic or semiautomatic fire)” and also “a rifle that resembles a military assault rifle but is designed to allow only semiautomatic fire”; 7 and

Whereas, state and federal legislation has defined a “high capacity magazine” as any magazine capable of holding more than 10 rounds of ammunition;10 and

Whereas, the AMA has a litany of policies concerning firearms, AMA policy H- 145.993 Restriction of Assault Weapons states: “Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high- rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the public of all assault-type weapons, bump stocks and related devices, high capacity magazines and armor piercing bullets”;9 and

Whereas, “eight of the shootings with the highest number of casualties happened within the past 10 years” and seven of those mass shootings utilized assault-type weapons;3 and

Whereas, from 1981 to 2017, “assault rifles accounted for 430 or 85.8% of the total 501 mass-shooting fatalities reported in 44 mass-shooting incidents”;5 and

Whereas, the recent shooting in El Paso, Texas, utilizing an assault-type weapon killed 22 people, injured 26 others, and currently ranks as the seventh deadliest mass shooting since 1949;4 and

Whereas, the recent shooting in Dayton, Ohio, utilizing an assault-type weapon with a magazine capable of carrying 250 rounds of ammunition, killed nine people and injured 27 others in only 32 seconds;11 and

Whereas, recent polling commissioned by the APA details the deleterious effect of mass shootings on Americans’ mental health: 79% experience stress at the possibility of a mass shooting, 32% cannot go anywhere without fearing a mass shooting, 33% cannot go to certain places/events due to fear of a mass shooting, and 24% change the way they live their lives due to fear of a mass shooting;1 and

Whereas, recent polling demonstrates a majority of Americans believe in banning high-capacity magazines (65%) and assault-type weapons (68%);8 and

Whereas, the United States previously banned the manufacture, transfer and possession of assault-type weapons and high-capacity magazines under the Violent Crime Control and Law Enforcement Act of 1994 until the law’s expiration on Sept. 14, 2004, due to a sunset provision;13 and

Whereas, “mass-shooting fatalities were 70% less likely to occur during the federal ban period”;13 and

Whereas, background checks are effective but alone are insufficient, as demonstrated by the 72.3% of mass shootings that utilized exclusively legally obtained weapons since 1982;12 and

Whereas, the APA has directly condemned the proposed correlations between mental health illness and firearm violence by stating: “Routinely blaming mass shootings on mental illness is unfounded and stigmatizing. Research has shown that only a very small percentage of violent acts are committed by people who are diagnosed with, or in treatment for, mental illness. The rates of mental illness are roughly the same around the world, yet other countries are not experiencing these traumatic events as often as we face them. One critical factor is access to, and the lethality of, the weapons that are being used in these crimes”;2 and

Whereas, both state and federal courts have consistently ruled banning assault-type rifles and high-capacity magazines does not contravene a citizen’s Second Amendment rights to bear arms;6 therefore, be it

RESOLVED, that ISMA, in the spirit of AMA policy H-145.993 Restriction of Assault Weapons, supports appropriate legislation that would ban the civilian sale and distribution of all assault-type weapons (such as high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as such) and high-capacity magazines.

# References:

1. American Psychological Association. 2019. *One-Third of US Adults Say Fear of Mass Shootings Prevents Them from Going to Certain Places or Events .* August

15. https:/[/www.a](http://www.apa.org/news/press/releases/2019/08/fear-mass-shooting)p[a.org/news/press/releases/2019/08/fear-mass-shooting.](http://www.apa.org/news/press/releases/2019/08/fear-mass-shooting)

1. American Psychological Association. 2019. *Statement of APA President in Response to Mass Shootings in Texas, Ohio .* August 4. https://[www.apa.org/news/press/releases/2019/08/statement-shootings.](http://www.apa.org/news/press/releases/2019/08/statement-shootings)
2. BBC. 2019. *America's gun culture in charts.* August 5. https://[www.bbc.com/news/world-us-canada-41488081.](http://www.bbc.com/news/world-us-canada-41488081)
3. Chavez, Nicole, Eric Levenson, and Amir Vera. 2019. *El Paso vigils bring together a city in mourning after mass shooting .* August 6. https://edition- m.cnn.com/2019/08/05/us/el-paso-shooting-monday/index.html.
4. DiMaggio C1, Avraham J, Berry C, Bukur M, Feldman J, Klein M, Shah N, Tandon M, Frangos S. 2019. "Changes in US mass shooting deaths associated with the 1994-2004 federal assault weapons ban: Analysis of open-source data." *J Trauma Acute Care Surg* 86(1):11-19.
5. Giffords Law Center. 2018. *Assault Weapons.* https://lawcenter.giffords.org/gun- laws/policy-areas/hardware-ammunition/assault-weapons/#state.
6. Merriam Webster Dictionary. 2019. *Assault Rifle.* https://www.merriam- webster.com/dictionary/assault%20rifle.
7. Parker, Kim, Juliana M Horowitz, Ruth Igielnik, J. Baxter Oliphant, and Anna Brown. 2017. *America’s Complex Relationship With Guns.* Pew Research Center.
8. American Medical Association. 2019. *Restriction of Assault Weapons H - 145.993.* https://policysearch.ama- assn.org/policyfinder/detail/assault%20weapon?uri=%2FAMADoc%2FHOD.xml- 0-550.xml.
9. Rose, Veronica. 2013. *Laws on High Capacity Magazines.* Jan 24. https://[www.cga.ct.gov/2013/rpt/2013-R-0039.htm.](http://www.cga.ct.gov/2013/rpt/2013-R-0039.htm)
10. Santhanam, Laura. 2019. *What we know about the El Paso and Dayton shooters’ guns.* August 6. https://[www.pbs.org/newshour/nation/why-the-weapons-used-in-](http://www.pbs.org/newshour/nation/why-the-weapons-used-in-) this-weekends-shootings-are-controversial.
11. Statista Research Department. 2019. *Mass shootings in the U.S.: legality of shooter's weapons, as of August 2019.* August 9. https://[www.statista.com/statistics/476461/mass-shootings-in-the-us-by-legality-](http://www.statista.com/statistics/476461/mass-shootings-in-the-us-by-legality-) of-shooters-weapons/.
12. United States Congress. 1993-1994. *H.R.3355 - Violent Crime Control and Law Enforcement Act of 1994.* September 13. https:/[/www.co](http://www.congress.gov/bill/103rd-)n[gress.gov/bill/103rd-](http://www.congress.gov/bill/103rd-) congress/house-bill/3355.

**LATE RESOLUTION 19-03 PREVENTING VAPING DEATHS**

Introduced by: Lisa Hatcher, MD, ISMA President Elect

Referred to:

Whereas, the U.S. Surgeon General, Jerome Adams, MD, has declared that vaping among youth has reached epidemic levels; and

Whereas, according to the 2018 Indiana Youth Tobacco Survey (IYTS), vaping has increased more than 300% since 2012; and

Whereas, the IYTS found that vaping has increased 387% among high school students and 358% among middle school students since 2012 and that between 2016 and 2018, nearly 35,000 more Indiana students used e-cigarettes; and

Whereas, in response, on Aug. 29, 2019, the Indiana State Department of Health, led by Health Commissioner Kris Box, MD, and directed by Governor Eric Holcomb, announced a three-prong strategy to reduce vaping among Indiana’s youth; and

Whereas, on Sept. 6, 2019, the Centers for Disease Control and Prevention (CDC) issued a Health Advisory announcing an outbreak of severe pulmonary disease associated with e-cigarette use; and

Whereas, as of Aug. 29, 2019, cases of the severe pulmonary disease associated with e-cigarette had been reported in 25 states, including at least 24 cases in Indiana; and

Whereas, on Sept. 6, 2019, the Indiana State Department of Health announced Indiana’s first vaping death; and

Whereas, as of Sept. 9, 2019, a total of five people in the U.S. had died from the severe pulmonary disease associated with e-cigarette use; therefore, be it

RESOLVED, that ISMA lend the association’s full support to the state’s initiatives to further reduce vaping; and be it further

RESOLVED, that ISMA support parity in state taxation between traditional cigarettes and e-cigarettes; and be it further

RESOLVED, that ISMA support the Alliance for a Healthier Indiana’s efforts to enact policies to reduce vaping rates, particularly among Indiana’s youth.

1. <https://www.congress.gov/bill/115th-congress/house-bill/6/text> [↑](#footnote-ref-1)
2. <http://iga.in.gov/legislative/laws/2019/ic/titles/025/#25-1-9.3-7> [↑](#footnote-ref-2)
3. <https://www.deadiversion.usdoj.gov/ecomm/e_rx/index.html> [↑](#footnote-ref-3)
4. <http://iga.in.gov/legislative/laws/2019/ic/titles/035/#35-48-3-9> [↑](#footnote-ref-4)
5. <http://www.hrpub.org/download/20131215/UJCM1-16900871.pdf> [↑](#footnote-ref-5)
6. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3995494/> [↑](#footnote-ref-6)
7. State Briefs [Internet]. The State of Obesity. [cited 2019Jul10]. Available from: https://www.stateofobesity.org/states/in/ [↑](#footnote-ref-7)
8. Russell J. Obesity rate climbing in Indiana, new study says. Indianapolis Business Journal [Internet]. Greg Morris; 2019Mar13 [cited 2019Jul10]; Available from: https://www.ibj.com/articles/72927-obesity-rate-climbing-in-indiana-new-study-says [↑](#footnote-ref-8)
9. Malik VS, Popkin BM, Bray GA, Despres JP, Hu FB. Sugar-sweetened beverages, obesity, type 2 diabetes mellitus, and cardiovascular disease risk. Circulation. 2010;121(11):1356-64. [↑](#footnote-ref-9)
10. Falbe J, Thompson HR, Becker CM, Rojas N, McCulloch CE, Madsen KA. Impact of the Berkeley Excise Tax on Sugar-Sweetened Beverage Consumption. American Journal of Public Health. 2016;106(10):1865-71. [↑](#footnote-ref-10)
11. Lee MM, Falbe J, Schillinger D, Basu S, McCulloch CE, Madsen KA. Sugar-Sweetened Beverage Consumption 3 Years After the Berkeley, California, Sugar-Sweetened Beverage Tax. American Journal of Public Health. 2019;109(4):637-9. [↑](#footnote-ref-11)
12. von Philipsborn P, Stratil JM, Burns J, Busert LK, Pfadenhauer LM, Polus S, et al. Environmental interventions to reduce the consumption of sugar‐sweetened beverages and their effects on health. Cochrane Database of Systematic Reviews. 2019(6). [↑](#footnote-ref-12)
13. [CMS: Historical (2017)](https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html) [↑](#footnote-ref-13)
14. National Hospital Price Transparency Report (2019) [↑](#footnote-ref-14)
15. [Indianapolis Business Journal, Study: Indiana hospitals charge private health plans 311% of what Medicare would pay (2019)](https://www.ibj.com/articles/73727-study-indiana-hospitals-charge-private-health-plans-311-of-what-medicare-would-pay) [↑](#footnote-ref-15)
16. [AMA Res H-155.969: Strategies to Address Rising Health Care Costs](https://policysearch.ama-assn.org/policyfinder/detail/pay%20for%20performance?uri=%2FAMADoc%2FHOD.xml-0-678.xml) (2018) [↑](#footnote-ref-16)
17. [AMA Res H-450.947: Pay-for-Performance Principles and Guidelines](https://policysearch.ama-assn.org/policyfinder/detail/Pay-for-Performance%20Principles%20and%20Guidelines%20H-450.947?uri=%2FAMADoc%2FHOD.xml-0-4071.xml) (2018) [↑](#footnote-ref-17)
18. Centers for Disease Control and Prevention, <https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm>. [↑](#footnote-ref-18)
19. <https://www.in.gov/sba/files/8.%20Tobacco%20Master%20Settlement%20Fund%20Presentation.pdf> [↑](#footnote-ref-19)
20. *Id.* [↑](#footnote-ref-20)
21. *Id.* [↑](#footnote-ref-21)
22. *Id;* note: this average is for monies received between 2012-2018. [↑](#footnote-ref-22)
23. Campaign for Tobacco Free Kids, Broken Promises to our Children: A State-by-State Look at the 1998 Tobacco Settlement 19 Years Later, December 13, 2017, available at <https://www.tobaccofreekids.org/assets/content/what_we_do/state_local_issues/settlement/FY2018/FY2018_state_settlement_report.pdf> [↑](#footnote-ref-23)
24. *Supra note 2.* [↑](#footnote-ref-24)
25. America’s Health Rankings, United Health Foundation, 2018, <https://www.americashealthrankings.org/explore/annual/measure/Overall/state/IN> [↑](#footnote-ref-25)
26. <http://iga.in.gov/legislative/laws/2019/ic/titles/025/#25-23-1-13.1> [↑](#footnote-ref-26)
27. <http://iga.in.gov/legislative/laws/2019/ic/titles/025/#25-23.4-3-1> [↑](#footnote-ref-27)
28. <https://www.theindianalawyer.com/articles/50763-lawsuit-filed-against-unlicensed-porter-county-midwife> [↑](#footnote-ref-28)
29. https://www.nbme.org/students/examfees.html [↑](#footnote-ref-29)
30. 2018: 21,607 students \* $1,275 = ~$27.5 million (this does not include travel costs); https://www.usmle.org/performance-data/default.aspx#2018\_step-2-cs [↑](#footnote-ref-30)
31. https://www.usmle.org/performance-data/default.aspx#2018\_step-2-cs [↑](#footnote-ref-31)
32. Espey, Eve, Dennis, Amanda, and Landy, Uta.”The importance of access to comprehensive reproductive health care, including abortion: a statement from women’s health professional organizations”

    *American Journal of Obstetrics and Gynecology* [January 2019](https://www.ajog.org/issue/S0002-9378(18)X0013-1). Volume 220, Issue 1, Pages (67–70). <https://www.ajog.org/article/S0002-9378(18)30756-7/fulltext> [↑](#footnote-ref-32)
33. ACOG Committee Opinion 612, November 2014. *Abortion Training and Education*

    <https://www.acog.org/-/media/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/co612.pdf?dmc=1&ts=20170926T2329467312> [↑](#footnote-ref-33)
34. ibid [↑](#footnote-ref-34)
35. <https://www.theatlantic.com/health/archive/2015/06/learning-abortion-in-medical-school/395075/> [↑](#footnote-ref-35)
36. Indiana State Medical Association, Public Policy Manual, Resolution 18-52, page 63. [↑](#footnote-ref-36)
37. Jerman, Jenna, et al. “Barriers to abortion care and their consequences for patients traveling for services: Qualitative findings from two states.” *Perspectives on sexual and reproductive healthI* 49.2 (2017): 95-102. [↑](#footnote-ref-37)
38. https://www.guttmacher.org/united-states/abortion [↑](#footnote-ref-38)
39. https://www.acog.org/Clinical-Guidance-and-Publications/Position-Statements/Decriminalization-of-Self-Induced-Abortion [↑](#footnote-ref-39)
40. Rowan, Andrea. “Prosecuting women for self-inducing abortion: Counterproductive and lacking compassion.” *Guttmacher Policy Review* 18.3 (2015): 70-76. [↑](#footnote-ref-40)
41. ibid [↑](#footnote-ref-41)
42. https://www.acog.org/About-ACOG/News-Room/News-Releases/2018/Criminalization-of-Self-Induced-Abortion-Intimidates-and-Shames-Women-Unnecessarily [↑](#footnote-ref-42)
43. https://www.sialegalteam.org/halt-criminalization [↑](#footnote-ref-43)
44. Goldberg, J, Mackenzie, R, Ye, W, Kadar, E, Narefsky, K, Dhanani, S. When Self-Abortion is A Crime: Laws that Put Women at Risk. *The National Institute of Reproductive Ethics.* June 2017. 24-25 [↑](#footnote-ref-44)
45. <https://rewire.news/article/2018/02/06/mississippi-woman-criminally-charged-pregnancy-outcome-home-birth/> [↑](#footnote-ref-45)