RESOLUTION

Subject: Judicial Council Discontinuation

Submitted by: KMA Board of Trustees

Referred to: Reference Committee

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WHEREAS, the 2018 KMA House of Delegates asked the KMA Board of Trustees to consider possible revisions to KMA's governance structure, including the incorporation of graduates of KMA's leadership programs into its overall governance structure including committees, commissions, and Board of Trustees; and

WHEREAS, the KMA Long Range Planning Commission devoted its meetings over the past year to this issue; and

WHEREAS, the Commission reviewed the KMA governance system "from the bottom up" by looking at committees and commissions, along with other facets of KMA and entities related to the KMA; and

WHEREAS, the Commission made recommendations to the board regarding possible changes to certain committees and commissions to enhance member participation, including the discontinuation of those that do not fit modern governance structures and operations; and

WHEREAS, the Commission recommended, and the Board agreed, that the KMA Judicial Council should be discontinued; and

WHEREAS, the KMA Judicial Council has not met in over twenty-three years; and

WHEREAS, KMA Legal Counsel provided an opinion on the work of the Judicial Council, pointing out that the Kentucky Board of Medical Licensure (KBML) has essentially taken over the role of investigating complaints against physicians, something that did not exist when the Judicial Council was formed over fifty years ago; and

WHEREAS, the organization could face significant legal issues and challenges if the Judicial Council investigated or took action since any action taken would have to be reported to the National Practitioner Data Bank; and

WHEREAS, KMA would be limited in any investigative action because it has no subpoena power and any information it might gather must be turned over to a court or other investigative body; and

WHEREAS, the Judicial Council is part of the KMA by-laws, which would need to be amended in order to discontinue its existence; now, therefore, be it

RESOLVED, that the KMA Judicial Council be discontinued and the KMA by-laws be amended by striking wording as outlined in the attached strikethrough version of the current by-laws:

# CONSTITUTION AND BYLAWS OF THE KENTUCKY MEDICAL ASSOCIATION

(Revised September 2017)

## CONSTITUTION



### Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

### Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

### Article Ill. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

### Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies, but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

### Article V. Officers

**Section 1.** The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary-Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

**Section 2.** The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

**Section 3.** All officers shall serve until their successors have been elected and installed.

**Section 4.** All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

### Article VI. House of Delegates

**Section 1.** The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the Delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session, annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

**Section 2.** Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. The following members shall be designated as ex-officio members of the House of Delegates of the Kentucky Medical Association and entitled to vote: Officers of the Association, Delegates and Alternate Delegates of the American Medical Association, and five immediate Past Presidents; the Dean of the University of Kentucky College of Medicine; the Dean of the University of Louisville School of Medicine; the Dean of the Pikeville College School of Osteopathic Medicine; a representative of the Resident and Fellows Section of the Kentucky Medical Association; a student representative of each medical school of Kentucky; and a representative of the Organized Medical Staff Section of the Kentucky Medical Association. All other Past Presidents and Vice-Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

**Section 3.** The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

**Section 4.** The House of Delegates shall be the final judge as to the qualification of its members.

### Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

### Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable, provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

### Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications, and for such other purposes as will promote the welfare of the Association and the profession.

### Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary-Treasurer, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary-Treasurer to the President and Board of Trustees.

### Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

### Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the Delegates registered at the Regular Session, provided that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

### Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual 3-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

## BYLAWS

## CHAPTER 1. MEMBERSHIP

**Section 1.** Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary-Treasurer as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary-Treasurer of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship. ~~And provided further, that the Judicial Council, after a hearing, shall have power to condition membership in this Association upon the physician's agreement to limit the scope of his practice in any manner reasonably calculated to protect the public from the adverse effects of any demonstrated frailty or disability of said member.~~

**Section 2.** Membership in the Association shall be divided into nine classes, to wit: Active, Life, In-Training, Associate, Inactive, Student, Service, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an active or limited license to practice medicine and surgery in this state, or a military physician who holds an active license in any US state or territory and who is posted or stationed in a military facility within the Commonwealth (to include Blanchfield Army Community Hospital, Fort Campbell, Kentucky) and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) Life Members. Component societies may elect as a life member any doctor of medicine or osteopathy who has served his profession with distinction and who has reached the age of 70 and has retired from active practice. Further, any member who has 25 years of continuous membership in a state medical society affiliated with the American Medical Association, who has reached the age of 65 and is fully retired, also may be elected as a life member. However, any member who had qualified as a life member at the time of the adoption of this amendment, September 26, 1990, shall continue to qualify as a life member. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8, of these Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

(c) Resident and Fellows Section. Doctors of medicine or osteopathy who have complied with all pertinent regulations of the Kentucky Board of Medical Licensure and who are serving in AMA approved training programs in Kentucky shall be eligible for membership in the Resident and Fellows Section of the Kentucky Medical Association. The Resident and Fellows Section shall be governed by its own Constitution and Bylaws, which shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. In-Training members in good standing shall have the right to vote and receive all publications of the Association. In-Training members shall not be counted in determining the number of Delegates to which their county society is entitled in the House of Delegates. The Resident and Fellows Section will be represented in the KMA House of Delegates by one voting representative elected by the Governing Council of the Resident and Fellows Section. The KMA Resident and Fellows Section President, elected by the Governing Council of the KMA Resident and Fellows Section, will represent the Section as a voting member of the KMA Board of Trustees.

(d) Associate Members. The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other federal governmental service while on duty in the State, but shall not be deemed to include physicians employed on a full-time basis by the Veterans Administration.

(2) Dentists may be invited to become Associate members.

(3) Physicians residing and/or practicing in communities bordering Kentucky who are active members of their home state and county society and who wish to become members of KMA on an other than active basis may become Associate Members.

Associate members shall not have the right to vote nor to hold office, but shall receive *The Journal* and other publications of the Association.

(e) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive *The Journal* and other publications of the Association.

(f) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for membership in the Medical Student Section of the Kentucky Medical Association. This Medical Student Section shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. Membership shall be coincident with the academic enrollment of the student. Student members may hold office within the Student Section in accord with the provisions of that Section's Constitution and Bylaws. The Student Section will be represented in the KMA House of Delegates through one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Kentucky College of Medicine, and one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Louisville School of Medicine. The KMA Medical Student Section President, elected by the Governing Council of the KMA Medical Student Section, will represent the Section as a voting member of the KMA Board of Trustees.

(g) Service Members. Members of the Association in good standing who enter military service and are ineligible for Associate membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to March 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to March 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by March 1 are not in good standing.

(h) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(i) Special Members. Component societies may invite pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

**Section 3.** Hospital Medical Staff Section. There shall be a special section for hospital medical staff physicians who already hold membership in KMA. The Hospital Medical Staff Section (HMSS) shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. The Hospital Medical Staff Section shall elect a Delegate and Alternate Delegate to the KMA House of Delegates. The Delegate to the KMA House of Delegates, or his Alternate as the case may be, shall be a voting member of the House and may present Resolutions on behalf of the HMSS.

**Section 4.** Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

~~**Section 5.** No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.~~

## CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

**Section 1.** The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

**Section 2.** The Annual Meeting shall consist of one or more education sessions, at least one meeting of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each education session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct.

**Section 3.** The name of a physician upon the properly certified roster of members or list of Delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

**Section 4.** Each member in attendance at any meeting shall register indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

## CHAPTER III. THE HOUSE OF DELEGATES

**Section 1.** The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give Delegates an opportunity to attend the education sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

**Section 2.** The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of fifty duly elected Delegates of the Association. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

**Section 3.** When a special session is called, the Secretary-Treasurer shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

**Section 4.** The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

**Section 5.** The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

**Section 6.** In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint an active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

**Section 7.** Forty percent of the qualified Delegates, as defined by Article VI of the Constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

**Section 8.** Each Resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary-Treasurer following its introduction. If the author presenting the Resolution presents it as an individual member of the Kentucky Medical Association, the Resolution shall be signed by him. If the author be a group of members or component society, the Resolution shall be signed by the authorized spokesman for that group. Prior to the meeting of the regular session of the House of Delegates, it shall be referred to the proper Reference Committee before action thereon is taken.

**Section 9.** No Resolution shall be introduced at the regular session of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least thirty days prior to its introduction. Resolutions furnished after the deadline will be considered as new business at the regular session of the House of Delegates and must include a showing that the issue addressed by the Resolution either did not exist or was unknowable until after the deadline. New business shall be introduced in the House only by unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those Delegates present and voting, for adoption.

**Section 10.** The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

**Section 11.** It shall consider and advise as to the material interests of the profession, and of the public, in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

**Section 12.** It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the Constitution, Bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

**Section 13.** It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

**Section 14.** It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

**Section 15.** It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

**Section 16.** The state shall be divided into the following districts:

No. 1 —- Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2 —- Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3 —- Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4 —- Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5 —- Jefferson.

No. 6 —- Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7 —- Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8 —- Boone, Campbell, and Kenton.

No. 9 —- Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10 —- Fayette, Jessamine, and Woodford.

No. 11 —- Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12 —- Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13 —- Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14 —- Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike,

No. 15 —- Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

**Section 17.** It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

**Section 18.** It shall approve all Memorials and Resolutions issued in the name of the Association before the same shall become effective, except as provided in Chapter VI, Section 4, and except for the selection of the recipient of the Kentucky Medical Association Award (Outstanding Layman), Distinguished Service Award (Outstanding Physician), and Community Service Award (Outstanding Physician), which selections shall be made by the KMA Awards Committee, and except for up to two Outstanding Advocacy Awards, which selections shall be made by the KMA Board of Trustees.

**Section 19.** A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually.

## CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

**Section 1.** The President-Elect and the Vice President shall be elected from the state at large for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. A majority vote of those attending and voting shall be required for the election of the President-Elect and the Vice President and on any ballot where a majority is not obtained, the candidate with the least votes shall be dropped and further balloting held until such time as one candidate receives a majority of the votes cast. Delegates to the AMA and their alternates shall be elected from the state at large for terms of two years with the provision that no more than one delegate and no more than one alternate delegate shall be elected from one component society except in the instance that a member of the Kentucky delegation is elected to the office of Speaker or Vice-Speaker of the American Medical Association House of Delegates, in which case, no more than two delegates and two alternate delegates shall be elected from any component society. All delegate and alternate terms shall be coterminous; all positions shall expire at the same time and all candidates must run for office at the same time every two years. The Speaker of the House of Delegates, the Vice-Speaker and the Secretary-Treasurer shall be elected for terms of three years. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice-President, Secretary-Treasurer, Speaker or Vice-Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least three years. Representatives of the KMA Resident and Fellows Section and the KMA Medical Student Section to the KMA Board of Trustees shall be elected for a term of one year.

**Section 2.** The Immediate Past President shall serve as the Nominating Review Authority to verify the eligibility and willingness to serve of each candidate nominated. Should the Immediate Past President be nominated for an elected office or is not available to serve as the Nominating Review Authority, the Speaker shall appoint another KMA officer who is not nominated for an elected office that year to serve as the Nominating Review Authority. The Nominating Review Authority shall accept and post for information all eligible and willing candidates proposed for offices elected from the state at large. On the second day of the Annual Meeting, the Nominating Review Authority shall post on a bulletin

board near the entrance to the hall in which the Annual Meeting is being held, the nomination, or nominations, for each office to be filled, and shall formally present said nomination, or nominations, to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment.

**Section 3.** The election of officers and Delegates to the AMA and their alternates shall be held at the meeting of the regular session of the House of Delegates.

**Section 4.** All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

**Section 5.** Any member may make known his availability for any office within the Association. However, it would be regarded as unseemly for any member to actively campaign for his own election.

## CHAPTER V. DUTIES OF OFFICERS OTHER THAN TRUSTEES AND ALTERNATES

**Section 1.** Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit or cause to be visited on his behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

**Section 2.** The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

**Section 3.** The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice-President shall succeed to the office of the President.

**Section 4.** The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

**Section 5.** The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a nonvoting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

**Section 6.** The Vice Speaker shall assume the duties of the Speaker in his absence and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

**Section 7.** The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or his designee and shall be countersigned by the Secretary-Treasurer of the Association. When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees. The Secretary-Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees. The Association's annual audit shall be made available to the membership.

## CHAPTER VI. BOARD OF TRUSTEES

**Section 1.** The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary-Treasurer, the Delegates and Alternate Delegates to the American Medical Association, the President of the KMA Resident and Fellows Section, and the President of the KMA Medical Student Section. The Executive Committee of the Board of Trustees shall consist of the President, the Vice-President, the President-Elect, the Secretary-Treasurer, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, and a majority of the full Executive Committee, to-wit, 5, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all the powers belonging to the Board except those powers specifically reserved by the Board to itself.

**Section 2.** The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates outlining the Association's activities for the previous year, including reports from each commission, along with a financial report. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

**Section 3.** Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement but this shall not be constituted to include his expenses in attending the Annual Meeting of the Association.

**Section 4.** The Board shall have the authority to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

**Section 5.** The *Journal of the Kentucky Medical Association* shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the *Journal* shall be elected by the Board. All money received by the *Journal* or by any member of its staff on its behalf, shall be paid to the Secretary-Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

**Section 6.** All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

**Section 7.** In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In the case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stead.

**Section 8.** The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary-Treasurer acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

**Section 9.** The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Secretary-Treasurer. He shall annually submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be made available to the membership.

He shall keep a record of all physicians in the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

~~**CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL**~~

~~**Section 1.** There is hereby created a Judicial Council composed of the Secretary-Treasurer of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.~~

~~To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or a Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.~~

~~It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary-Treasurer shall serve more than two consecutive terms.~~

~~**Section 2.** The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All charges of breach of medical ethics brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the Constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine shall be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Medical Licensure for this purpose.~~

~~Suspension shall be for a specified period during which the member shall remain liable for the payment of dues but shall not be eligible to hold office, attend business meetings or otherwise participate in Associational activities at the county, district or state levels. Upon the expiration of the period of suspension, every suspended member shall be automatically restored to all of the rights and privileges of his class of membership unless the Judicial Council determines that his conduct during the period of suspension indicates that he is unworthy of such restoration, in which event his suspension may be extended or he may be expelled.~~

~~Upon the complaint of any member or aggrieved individual involved, the Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustee, for a determination as to whether probable cause for disciplinary action exists. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent, and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.~~

~~In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be observed. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.~~

~~**Section 3.** It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In this case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.~~

~~**Section 4.** The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.~~

~~**Section 5.** Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final. A party aggrieved by the decision of the Judicial Council may seek an appeal to the Judicial Council of the American Medical Association in accordance with the jurisdiction, rules and regulations of that Association.~~

~~**Section 6.** Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.~~

~~**Section 7.** The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.~~

~~**Section 8.** District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable Judicial Council to form its own conclusions.~~

~~If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.~~

~~When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.~~

~~**Section 9.** Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary-Treasurer a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.~~

~~**Section 10.** No report or opinion of the Judicial Council shall be considered the policy of the Association until approved by the House of Delegates. Any report or opinion of the Judicial Council submitted to the House of Delegates may be accepted or rejected or referred back to the Judicial Council but not modified by the House of Delegates.~~

**CHAPTER VII ~~VIII~~. COMMITTEES AND COMMISSIONS**

**Section 1.** The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

**Section 2.** The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

**Section 3.** The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary ad hoc committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

**Section 4.** No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

**CHAPTER VIII ~~IX~~. ASSESSMENTS AND EXPENDITURES**

**Section 1.** The annual dues for membership in this Association shall be as follows: (1) Active Members, $530, (except (a) those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government-obligated service shall pay only one-half of the full active member rate their first full year of membership; (b) those physicians in their second year of practice shall pay only three-fourths of the full active member rate for their second full year of membership; and (c) those physicians who have reached the age of 70 and work 20 hours or less per week shall pay only one-half of the full active member rate per year for their KMA membership); (2) Life Members, no dues; (3) Associate Members, $100; (4) Physician In-training Members, $25 one-time fee for the duration of residency and fellowship in an approved residency program in Kentucky, except that physician In-training Members joining prior to September 10, 2003, shall not be liable for additional dues for the duration of residency and fellowship; (5) Inactive Members, $100; (6) Student Members, no dues; (7) Service Members, no dues; (8) Special Members, no dues. The dues during the first year for any active member shall be prorated on a quarterly basis as determined by the date of the application. Dues fixed by these Bylaws shall constitute assessments against the component societies. Unless otherwise instructed by the Board of Trustees (which may institute centralized billing) the Secretary of each component society shall forward its assessments, together with its properly classified roster of all officers and members, list of

delegates, and list of nonaffiliated physicians of the county, to the Secretary-Treasurer of this Association as of the first day of January each year.

**Section 2.** Unless otherwise provided by the Board of Trustees pursuant to Section I hereof, any component society which fails to pay its assessments, or make the report as required, on or before the first day of March in each year, shall be held as suspended and none of its members or Delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

**Section 3.** All motions and Resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or Resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or Resolution.

## CHAPTER IX ~~X~~. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted Resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

## CHAPTER X ~~XI~~. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in the latest edition of Sturgis's *Standard Code of Parliamentary Procedure*, unless otherwise determined by a vote of its respective bodies.

## CHAPTER XI ~~XII~~. COUNTY SOCIETIES

**Section 1.** Except as provided in Section 3 of this Chapter, all county medical societies in this State which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

The House of Delegates shall have authority to revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws.

**Section 2.** As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

**Section 3.** Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

**Section 4.** In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting Resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the Resolution, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or Delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 11 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

A multi-county component society may be disaggregated so that an individual county society may regain independent status when a majority of the members in that county indicate their desire to reorganize. At that time the members from the withdrawing county shall forward a petition containing the signatures of a majority of the members in that county to be validated by KMA. The withdrawing county shall further forward a Resolution to the KMA Headquarters Office to be submitted to the House of Delegates at its next regular meeting, requesting recognition as a county society and issuance of a charter, in accord with Chapter XII, Section 1 of the KMA Bylaws. Once this charter is issued, the new county society shall become a recognized entity at the beginning of the following KMA dues year and those counties remaining with the original multi-county unit may continue to function under their pre-existing charter.

**Section 5.** Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 6 and/or 8 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

**Section 6.** Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

**Section 7.** When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

**Section 8.** A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

**Section 9.** Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

~~Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days, appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.~~

~~Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership, provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.~~

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

**Section 10.** Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

**Section 11.** At the time of the annual election of officers, each component society shall elect a delegate or Delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect Delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of Delegates as its component societies would have had. The secretary of the society shall send a list of such Delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects Delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its Delegates each year.

**Section 12.** The secretary of each component society shall keep a roster of its members and a list of nonaffiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

## CHAPTER XII ~~XIII~~. AMENDMENTS

**Section 1.** These bylaws may be amended at the meeting of the regular session of the House of Delegates by a majority vote of the Delegates present if the amendment proposed is presented in writing to the Delegates thirty days prior to the meeting.

**Section 2.** An amendment to or change in the bylaws may be proposed by a reference committee or by the Board of Trustees at the meeting of the regular session of the House of Delegates and may be voted on at that meeting. Passage requires a two-thirds vote.

**Section 3.** An amendment to these bylaws may be proposed in writing by an individual Delegate at the meeting of the regular session of the House of Delegates. If such an amendment is proposed, the proposal will be postponed definitely and studied

by the appropriate reference committee at that time, reporting their recommendation back to the House of Delegates before the meeting is adjourned. Passage of such an amendment requires a two-thirds vote.

RESOLUTION

Subject: Networking Opportunities for Young Physicians

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, young physicians, trainees, and medical students are typically under the age of 40, beginning their careers and families; and

WHEREAS, the Kentucky Medical Association membership for this demographic has been dropping in the last few years, the Commission for Young Physicians was dissolved due to inactivity; and

WHEREAS, young physicians are seeking networking and mentoring opportunities with physicians across health systems and across the age spectrum to help build their experience; and

WHEREAS, encouraging activities that are family friendly could inspire more young physicians to become involved in the KY Medical Association; and

WHEREAS, the Lexington Medical Society has improved physician wellness by promoting family-oriented activities; now, therefore, be it

RESOLVED, that the Kentucky Medical Association and the Kentucky Medical Association Alliance utilize the Lexington Medical Society Physician Wellness Program events as an example and explore and implement more family friendly networking opportunities to encourage better membership and involvement for young physicians.

RESOLUTION

Subject: Physician Owned Hospitals

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, since 2010, 95 rural hospital have closed across the nation, including 4 hospitals in the commonwealth of Kentucky (North Carolina Rural Health Research Program). Many more hospitals are struggling to keep their doors open and are likely to close in the next few years; and

WHEREAS, a recent large study demonstrated that POHs may treat slightly healthier patients, but do not systematically avoid Medicaid patients or those from ethnic and racial minority groups. Moreover, overall costs of care, payments for care and quality of care are similar between physician owned hospitals (POHs) and non-POHs. (Harvard Study); and

WHEREAS, hospitals that have any physician ownership, are known for top-notch healthcare with an incentive for physicians to maintain high quality of care with Physician-owned hospitals crediting their high patient satisfaction rates due to freedom from administrative layers; and

WHEREAS, Physician Hospitals of America (PHA) announced in 2012, that 16 of the 37 winners of the prestigious Inpatient Patient Satisfaction Summit Award were POHs; and

WHEREAS, lifting restrictions on physician-owned hospitals could be key to widening access to care; and

WHEREAS, the AMA and Coalition of State Medical Societies strongly support removing the ban on the construction or expansion of POHs; now, therefore, be it

RESOLVED, that the Kentucky Medical Association study available data and educate physicians about the benefits and consequences of legislation which would allow a pathway to physician owned hospitals.

References

[1] https://www.modernhealthcare.com/article/20170627/NEWS/170629899/lifting-restrictions-on-physician-owned-hospitals-could-be-key-to-widening-access-to-care
[2] https://www.ama-assn.org/advocacy/physician/house-bill-would-repeal-limits-physician-owned-hospitals
[3] https://www.modernhealthcare.com/article/20180214/NEWS/180219961/azar-eyes-relaxing-restrictions-on-physician-owned-hospitals

RESOLUTION

Subject: Confidential Physician Reporting via Kentucky Board of Medical Licensure

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, nearly one in five Americans (18%) have experienced an interaction with a physician who they believe was acting unethically, unprofessionally, or providing substandard care[1]; and

WHEREAS, only one-third (33 percent) of those who believe they experienced unethical, unprofessional, or substandard care report the misconduct or file a complaint; and

WHEREAS, physicians also underreport impaired or unprofessional colleagues, citing reputational risks and concern they may jeopardize interprofessional relations; and

WHEREAS, the inability to make anonymous complaints and avoid being identified during hearing processes contributes to a culture that discourages reporting of adverse events and clinical conditions; and

WHEREAS, the Kentucky Board of Medical Licensure website states anonymous grievances are not trusted and requires each grievance to be signed and notarized, including the name and contact information of the grievant; and

WHEREAS, the Federation of State Medical Boards House of Delegates unanimously adopted new policy in 2016 that state medical boards should ensure that appropriate protections are in place to enable physicians to complain anonymously, and where allowing anonymous complaints is impossible or infeasible, ensure that complainants' identities remain confidential and that licensees who have a complaint before the board be discouraged from attempting to contact complainants; now, therefore, be it

RESOLVED, that the Kentucky Medical Association encourage the Kentucky Board of Medical Licensure to acknowledge a pathway for anonymous reporting for physicians if substantiated by sufficient evidence; and be it further

RESOLVED, that the Kentucky Medical Association discourage licensees from contacting or taking action against a complainant, provided the grievance is filed in good faith.

References

[1] State Medical Boards Awareness Study. http://www.fsmb.org/siteassets/advocacy/news-releases/2018/harris-poll-executive-summary.pdf

[2] Campbell EG et al. Professionalism in Medicine: Results of a National Survey of Physicians. Ann Intern Med 2007;147:795–802. doi: 10.7326/0003-4819-147-11-200712040-00012

[3] Position Statement on Duty to Report, Federation of State Medical Boards. http://www.fsmb.org/SysSiteAssets/advocacy/policies/position-statement-on-duty-to-report.pdf

RESOLUTION

Subject: Anonymous Reporting of Licensees to the Kentucky Board of Medical Licensure

Submitted by: Naren James, MD

Referred to: Reference Committee

WHEREAS, current KBML policy permits complaints to be filed with the Board against a physician by individuals who remain anonymous; and

WHEREAS, such anonymous reporting can be potentially abused by adversaries of a physician by initiating Board action against that physician's license; and

WHEREAS, this current policy is contrary to basic due process that should be available to every physician; and

WHEREAS, anonymous complaints invariably result in action by the licensing Board; and

WHEREAS, the mere initiation of such action results in tangible hardship to physicians; and

WHEREAS, the sixth district United States federal court of appeals has already ruled that certain anonymous reporting of citizens are an unconstitutional infringement on the federal constitutional right to due process; now, therefore, be it

RESOLVED, that the Kentucky Medical Association take a policy position against such an anonymous reporting all physicians; and be it further

RESOLVED, that KMA advocate before the legislature for statutory protection for physicians from this current policy.

RESOLUTION

Subject: Support for the *Stop the Bleed* Campaign and Increased Availability of Bleeding Control Supplies

Submitted by: Jessica Geddes, Grant Austin, Curtis Bethel, Stuart Jones, Kaitlyn Kasemodel, Pat Osterhaus, Samantha Ruley (University of Kentucky College of Medicine)
Rachel Safeek, MPH (University of Louisville School of Medicine)

Referred to: Reference Committee

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WHEREAS, active shooter and other explosive events are a growing public health concern, affecting communities throughout the nation[1]; and

WHEREAS, uncontrolled bleeding is the number one cause of preventable death from trauma[2]; and

WHEREAS, one way to save lives is through educating both lay public and professional responders on proper bleeding control techniques[1,2]; and

WHEREAS, *Stop the Bleed* is a national awareness campaign created in 2015 through collaboration between several highly respected government and medical groups, including Homeland Security and the American College of Surgeons, with the goal of encouraging civilians to become trained, equipped and empowered to help in a bleeding emergency[3,4]; and

WHEREAS, approximately 130,000 people have taken a *Stop the Bleed* course nationwide, and the training has already saved lives[5,6;]; and

WHEREAS, *Stop the Bleed* training events and other *Stop the Bleed* resources are currently available throughout Kentucky[7]; and

WHEREAS, effective bystander intervention in medical emergencies is crucial in the state of Kentucky, where nearly 41% of the population lives in rural areas[8], which experience higher wait times for EMS personnel[9]; and

WHEREAS, current AMA Policy H-130.935 Support for Hemorrhage Control Training encourages state medical societies to promote bleeding control training as well as the availability of bleeding supplies[10]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association promote the national public health educational campaign *Stop the Bleed* within the Commonwealth of Kentucky; and be it further

RESOLVED, that the KMA support the increased availability of hemorrhage control supplies (including pressure bandages, hemostatic dressings, tourniquets and gloves) in schools, places of employment, and public buildings.

## References

[1] "Stop the Bleed" Programs Save Lives: Learn How to Participate with This Checklist | PAMED. May 30, 2019.
[2] What Everyone Should Know to Stop Bleeding After an Injury. BleedingControl.com. American College of Surgeons. 2017.
[3] Office of EMS: Stop the Bleed.
[4] Stop the Bleed. Department of Homeland Security. June 7, 2018.
[5] Hughes, Lisa. Homeland Security 'Stop the Bleed' Initiative Aims to Improve Survival Rates. CBS Boston. December 7, 2018.
[6] Surgeons: Lessons from Orlando, Las Vegas Saved Lives after Squirrel Hill Attack. Pittsburgh Post-Gazette. October 31, 2018.
[7] Class Search. Bleeding Control.com.
[8] Kentucky. Rural Health Information Hub. January 8, 2018.
[9] Mell, Howard K. et al. Emergency Medical Response Times in Rural, Suburban, and Urban Areas. JAMA Surgery. 2017 Oct; 152(10): 983–984.
[10] Support for Hemorrhage Control Training H-130.935. American Medical Association.

**RELEVANT AMA AND KMA POLICY**

**Support for Hemorrhage Control Training H-130.935**

1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.
2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.
3. Our AMA supports the increased availability of bleeding control supplies with adequate and relevant training in schools, places of employment, and public buildings.

RESOLUTION

Subject: Increasing Standards for Childhood Nutrition in Schools

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the Kentucky Medical Association recognizes that adolescent obesity is an increasing epidemic causing significant morbidity and mortality, burden to the healthcare system and larger economic implications; and

WHEREAS, Kentucky has the fifth highest rate of obesity and 20% of Kentucky high school students are obese; and

WHEREAS, the school lunch program has a major impact on the nutrition of students throughout Kentucky, not all foods brought to school meet USDA nutrition standards. Foods brought to schools for celebrations, packed-lunches and extra-curricular activities are not held to recognized nutritional standards; and

WHEREAS, the USDA Dietary Guidelines are designed and supported by experts who specialize in nutrition with an emphasis on addressing public health concerns and nutrition needs of the population, including adolescents; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports measures that encourage all food items, especially those provided by schools, but also including food brought by families for celebration and extracurricular activities to meet the USDA Nutrition standards for foods that compete with healthy school lunches, as well as provide families with evidence-based nutritional education, and encourage its members to promote healthy nutritional choices based on the USDA Dietary Guidelines for America.

References

[1] AMA Supports Newest Dietary Guidelines to Improve Public Health. January 2016. https://www.ama-assn.org/press-center/ama-statements/ama-supports-newest-dietary-guidelines-improve-public-health
[2] Snacks, Sweetened Beverages, Added Sugars, and Schools. Council on School Health, Committee on Nutrition. Pediatrics. March 2015. 135.3. https://pediatrics.aappublications.org/content/135/3/575
[3] Adolescent Obesity Prevalence: Trends Over Time. CDC Health Schools. 2017. https://www.cdc.gov/healthyschools/obesity/obesity-youth.htm
[4] USDA Dietary Guidelines. https://health.gov/dietaryguidelines/
[5] CDC Healthy Schools: Childhood Nutrition Facts. May 2017. https://www.cdc.gov/healthyschools/nutrition/facts.htm
[6] Obesity. Chronic Disease Prevention. Kentucky Cabinet for Health and Family Services. https://chfs.ky.gov/agencies/dph/dpqi/cdpb/Pages/obesity.aspx

RESOLUTION

Subject: Promotion of Vaccine Education and the Elimination of the Non-Medical Exemption

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, vaccination has made an enormous contribution to global health leading to the eradication of smallpox and rinderpest, and the near eradication of polio and significantly decreased the morbidity and mortality caused by many previously common childhood illnesses; and

WHEREAS, anti-vaccination efforts are as old as vaccination itself and are not likely to disappear; and

WHEREAS, recent increases in non-vaccinated children has led to major outbreaks of measles and chicken pox resulting in deaths in several states; and

WHEREAS, a minority of parents hold strong anti-vaccination sentiment, the proportion of parents categorized as vaccine-hesitant is increasing and anti-vaccination groups increasingly encourage parents to request vaccine exemptions of religious grounds; and

WHEREAS, the Commonwealth of Kentucky allows for vaccine exemptions if, in the written opinion of the attending physician, such vaccine would be injurious to the patient's health, or if a parent of a child objects by a written sworn statement to the immunization of the child on religious grounds; and

WHEREAS, many physicians may not know what the world's major religions teach about vaccines and immunizations; now, therefore, be it

RESOLVED, that the Kentucky Medical Association (KMA) believes that nonmedical (religious, philosophical, or personal belief) exemptions from immunizations endanger the health of the unvaccinated individual and the health of those in his or her group and the community at large; and be it further

RESOLVED, that the KMA (1) supports the immunization recommendations of the Advisory Committee on Immunization Practices (ACIP) for all individuals without medical contraindications; (2) supports legislation eliminating nonmedical exemptions; (3) supports public education efforts to address vaccine hesitancy and refusal; (4) educates its member physicians as to what the world's major religions teach about vaccines and immunization practices.

RESOLUTION

Subject: Requirement of Helmet Usage Amongst the Youth of Kentucky While on a Bicycle or Powered Cycle

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

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WHEREAS, unintentional injuries are consistently the leading cause of death for children 1-18 years old in the United States, and to address the issue the CDC has researched and advocated for universal helmet laws for children; and

WHEREAS, between 1987 and 1998 it was found that helmets reduced head injuries by 60% and fatality from a head injury by 73% in communities that adapted helmet requirement laws. This was again confirmed by a Cochrane review in 2011 demonstrating a significant reduction in injury rate between 63% and 88% overall; and

WHEREAS, the Commonwealth of Kentucky has not followed the trend of almost half of the United States in implementing a statewide helmet law for children; and

WHEREAS, education has been proven to be influential in helmet usage, education in concordance with governmental regulations has shown exponential increase in helmet usage when compared to just education; and

WHEREAS, helmet compliance is at the root of solving the issue, and passage of a helmet requirement law has been associated with the increase of the usage of helmets; and

WHEREAS, it is important to protect the children of Kentucky with the implementation of a law requiring helmets on bicycles and low powered cycles, including electronic scooters and mopeds; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support helmet regulations to require a helmet to be worn by those 17 years of age and younger, while on a bicycle or low-powered cycles, including, but not limited to: scooters, mopeds, and electronic scooters; and be it further

RESOLVED, that the Kentucky Medical Association support universal helmet regulation laws for children for the Commonwealth of Kentucky; and be it further

RESOLVED, the Kentucky Medical Association support and encourage the development of public education campaigns for helmet usage by children.

RESOLUTION

Subject: Protection of Minors from Risks of Indoor Tanning

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the dangers of excess ultraviolet radiation are undeniable and include the development of melanoma and non-melanoma skin cancer, cataracts and premature aging, such that tanning bed radiation is now considered a Category 1 carcinogen, similar to tobacco and mustard gas; and

WHEREAS, in 2014 the FDA re-categorized indoor tanning beds as class II devices, indicating that their use carries risk, and sunlamp products now contain black box warnings stating that they should not be used by individuals under the age of 18; and

WHEREAS, the American Academy of Dermatology and American Medical Association support legislative efforts to prohibit use of tanning beds by minors under age 18; and

WHEREAS, in 2010 the KMA resolved to support the enactment of state legislation to protect minors from the hazards of indoor tanning by prohibiting the sale of tanning salon ultraviolet rays to those under 18 years of age *(Res 2010-16, 2010 HOD, p 422),* but no changes were made to Kentucky law as a result; and

WHEREAS, since 2006 Kentucky law has allowed minors age 14 – 17 to use tanning beds with signed parental consent documenting awareness of risks of tanning bed use, and minors under age 14 must be accompanied by a parent or legal guardian but are otherwise not restricted in tanning bed use; and

WHEREAS, studies have shown that laws aiming to decrease indoor tanning by requiring parental consent are ineffective, exemplified by Kentucky tanning bed facilities found to have 30% compliance with current laws[1]; and

WHEREAS, in light of these regulatory changes and increased knowledge of harms of UV exposure, especially at an early age, most states in the United States have enacted legislation banning their use in minors; now, therefore, be it

RESOLVED, that the Kentucky Medical advocate that the Kentucky General Assembly pass legislation to prohibit tanning bed use in individuals under the age of 18.

References

[1] *JAMA Dermatol.* 2018;154(1): 67-72.

RESOLUTION

Subject: Educate Families about Gun Safety

Submitted by: Lexington Medical Society

Referred to: Reference Committee

WHEREAS, the American Medical Association[1] and the Annals of Internal Medicine have declared gun violence a “public health crisis” and the latter endorsed a required educational program prior to purchasing a firearm[2]; and

WHEREAS, according Everytown for Gun Safety since 2013 there were at least 465 incidents of gunfire on school grounds causing 181 deaths and 358 injuries[3]; and

WHEREAS, the Washington Post found that 80% of perpetrators of gun violence in schools had obtained their weapon from home, or those of relatives or friends; and

WHEREAS, a study conducted by Every Town for Gun Safety confirmed that nearly 2 million American children live in homes that do not have adequate safety measures in place for storing firearms; and

WHEREAS, The Journal of Trauma Injury, Infection and Critical Care found a direct correlation between firearm availability and accidental gun deaths among youth[4]; and

WHEREAS, according to the US General Accounting Office 31% of accidental deaths caused by firearms could be prevented with the addition of a lock and an indicator showing whether the weapon is loaded[5]; and

WHEREAS, according to the CDC yearly 500 children die from gun suicides annually; and

WHEREAS, states with safe storage laws (laws that require guns to be stored, locked and unloaded when any person prohibited from possessing a gun-i.e. minors-is present in the gun owners home) have had a decrease in accidental child firearm deaths by 23% and 14% decrease in youth suicide deaths; and

WHEREAS, the American Medical Association in 2019, “encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms”; now, therefore, be it

RESOLVED, that the Kentucky Medical Association will formally support firearm education for guardians of minors in Kentucky in accordance with our parent organization, the American Medical Association.

References

[1] https://www.ama-assn.org/press-center/press-releases/ama-calls-gun-violence-public-health-crisis
[2] https://annals.org/aim/fullarticle/2709820/reducing-firearm-injuries-deaths-united-states-position-paper-from-american
[3] https://everytownresearch.org or https://everytownresearch.org/gunfire-in-school/#12510
[4] https://journals.lww.com/jtrauma/Abstract/2002/02000/Firearm_Availability_and_Unintentional_Firearm.11.aspx
[5] https://www.gao.gov/products/PEMD-91-9
[6] https://economics.adelaide.edu.au/research/papers/doc/wp2001-06.pdf3

RESOLUTION

Subject: Education on the Prevention of Firearm-Related Injuries and Deaths

Submitted by: Rachel Safeek, MPH, Jerome Soldo, Suzanne McGee, MD
(University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, approximately 40,000 Americans die and 85,000 more are injured each year due to firearm-related causes, including interpersonal violence, suicide, and accidents[1]; and

WHEREAS, the incidence of firearm-related mortality in the U.S. has increased in a 10-year period, from 10.3 deaths per 100,000 in 2007 to 12.0 deaths per 100,000 in 2017[1]; and

WHEREAS, there have been 35,664 incidents of documented firearm-related violence so far in 2019, including 262 mass shootings, defined as 4 or more people injured or killed in one event[2]; and

WHEREAS, notwithstanding mass shooting events, about 100 Americans are killed and hundreds more are injured each day in the United States due to incidents involving firearms[3]; and

WHEREAS, firearm-related deaths are the second leading cause of death for children in the U.S.[3]; and

WHEREAS, access to a firearm increases the risk of death by suicide 3-fold, and rates of firearm suicides are highest in states with high firearm ownership[3]; and

WHEREAS, prevention of avoidable firearm-related injury and death, and treatment of firearm-related morbidity lies within the purview of medicine; and

WHEREAS, physician-led firearm counseling was ruled protected under First Amendment rights by *Wollschlaeger v. Governor, State of Florida,* which invalidated Florida's Firearm Owners' Privacy Act that prevented physicians from asking patients about firearm ownership[4]; and

WHEREAS, two thirds of U.S. non-firearm owners and over 50% of firearm owners believe that physician-led discussions about firearms are at least sometimes appropriate[5]; and

WHEREAS, existing Kentucky Medical Association policy supports efforts that label violence caused by the use of firearms as a public health epidemic; and

WHEREAS, American Medical Association policy H-145.976 advocates for "strategies for counseling patients on safe gun storage and use in undergraduate medical education"; now, therefore, be it

RESOLVED, that the Kentucky Medical Association work with the Kentucky Board of Medical Licensure, the Kentucky Hospital Association, and Kentucky medical schools and residency programs to support evidence-based training for medical students, resident physicians, and teaching physicians to reduce firearm-related morbidity and mortality; and be it further

RESOLVED, that the Kentucky Medical Association partner with these organizations to establish best firearm safety practice guidelines for Kentucky medical students and resident and teaching physicians, emphasizing safer firearm storage and handling, evaluating risk of firearm-related suicide, and treating victims of firearm-related violence; and be it further

RESOLVED, that the Kentucky Medical Association encourage physicians, when appropriate, to counsel patients on best practices for firearm safety.

References

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999-2017 on CDC WONDER Online Database, released 2018.
[2] Gun Violence Archive. https://www.gunviolencearchive.org. Accessed August 7, 2019.
[3] Everytown for Gun Safety Support Fund. https://everytownresearch.org/gun-violence-america. Accessed August 7, 2019.
[4] Parmet W, Smith J, Miller M. Physicians, Firearms, and Free Speech: Overturning Florida's Firearm-Safety Gag Rule. *The New England Journal of Medicine.* 2017. 376:1901—1903.
[5] Betz ME, Azrael D, Barber C, Miller M. Public Opinion Regarding Whether Speaking With Patients About Firearms Is Appropriate: Results of a National Survey. *Annals of Intern Medicine*. 2016. 165:543—550.

RESOLUTION

Subject: Protecting Our Patients Amidst a Changing Climate

Submitted by: Jerome Soldo, Nolan Smith, Jacob Shpilberg (University of Louisville School of Medicine), Alexander Thebert, Patrick Osterhaus (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, it is the consensus of the U.S. and international scientific community that average global temperatures have been steadily increasing, a phenomenon that can be attributed in large part to human activity[1,2,3,4]; and

WHEREAS, climate change is already creating conditions that harm the health of Kentuckians, including through the physical and psychological consequences of extreme storms, the personal and economic costs incurred by flooding and droughts, the increasing incidence of vector-borne diseases, the diminishing air quality, and the growing risk of food insecurity and unsafe drinking water[5,6,7,8,9,10,11]; and

WHEREAS, one specific example of how warming temperatures and diminishing air quality negatively affect human health is that daily maximum temperatures and degree of air pollution have been shown to have a statistically significantly association with adverse respiratory and cardiovascular outcomes and even death[12, 13]; and

WHEREAS, the World Health Organization (WHO) and the American Medical Association (AMA) have called climate change “the greatest public health challenge of the 21st century”[8]; and

WHEREAS, despite the AMA supporting medical schools incorporating climate change topics into curricula, only 20 of 140 surveyed have a class that includes information on environmental health or global warming[14]; and

WHEREAS, to address the serious and time-sensitive threat of climate change, the Medical Society Consortium on Climate & Health was established by member organizations including the AMA, American Academy of Family Physicians, American Academy of Pediatrics, American Psychiatric Association, American College of Physicians, Infectious Diseases Society of America, and many others[15]; and

WHEREAS, joining the Consortium is an obligation-free, cost-free task that requires only endorsing the Consortium’s statement (below)[15]; and

WHEREAS, the health profession is among the most trusted in society, viewed as having no direct vested interest in policy decisions related to climate change other than their commitment to protect and improve human health and well-being[8,16]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association acknowledge the deleterious effects that climate change has on health; and be it further

RESOLVED, that the KMA support educating the medical community about the adverse effects of climate change on health; and be it further

RESOLVED, that the KMA endorse the Consensus Statement of the Medical Society Consortium on Climate and Health, thereby becoming an affiliate member of the Consortium; and be it further

RESOLVED, that the KMA establish an ad-hoc committee, which will be tasked with reporting back at the 2020 KMA Annual Meeting, to investigate the ways climate change is affecting Kentuckians and to develop a strategy for best communicating these findings to members, patients, and the Kentucky legislature.

Consensus Statement from the Medical Society Consortium on Climate & Health:

*We – the undersigned medical societies – support the international scientific consensus, as established in multiple national and international assessments, that the Earth is rapidly warming, and that human actions (especially burning of fossil fuels) are the primary causes. As established in the 2016 U.S. Climate and Health Assessment – The Impacts of Climate Change on Human Health in the United States: A Scientific Assessment – the resulting changes in our climate are creating conditions that harm human health through extreme weather events, reduced air and water quality, increases in infectious and vector-borne diseases, and other mechanisms. While climate change threatens the health of every American, some people are more vulnerable and are most likely to be harmed, including: infants and children; pregnant women; older adults; people with disabilities; people with pre-existing or chronic medical conditions, including mental illnesses; people with low-income; and indigenous peoples, some other communities of color, and immigrants with limited English proficiency.*

*As medical professionals, many of our members know firsthand the harmful health effects of climate change on patients. We know that addressing climate change through reduction in fossil fuel use will lead to cleaner air and water, to immediate health benefits for Americans, and will help to limit global climate change.*

*We support educating the public and policymakers in government and industry about the harmful human health effects of global climate change, and about the immediate and long-term health benefits associated with reducing greenhouse gas emissions (i.e., heat-trapping pollution) and taking other preventive and protective measures that contribute to sustainability. We support actions by physicians and hospitals within their workplaces to adopt sustainable practices and reduce the carbon footprint of the health delivery system.*

*We recognize the importance of health professionals' involvement in policy-making at the local, state, national, and global level, and support efforts to implement comprehensive and economically sensitive approaches to limiting climate change to the fullest extent possible.*

*Our organizations are committed to working with officials at all levels to reduce emissions of heat-trapping pollution, and to work with health agencies to promote research on effective interventions and to strengthen the public health infrastructure with the aim of protecting human health from climate change.*

KMA House of Delegates
September 2019

## References


[1] USGCRP. Climate Science Special Report. https://science2017.globalchange.gov/. Accessed August 15, 2019.
[2] Organization (WMO) WM, World Meteorological Organization (WMO). *WMO Statement on the State of the Global Climate in 2018*. WMO; 2019.
[3] AR5 Synthesis Report: Climate Change 2014 — IPCC. https://www.ipcc.ch/report/ar5/syr/. Accessed August 15, 2019.
[4] Global Environment Outlook 6. UN Environment. http://www.unenvironment.org/resources/global-environment-outlook-6. Accessed August 15, 2019.
[5] USGCRP. Fourth National Climate Assessment. https://nca2018.globalchange.gov. Published 2018. Accessed August 15, 2019.
[6] Climate and Human Health. National Institute of Environmental Health Sciences. https://www.niehs.nih.gov/research/programs/geh/climatechange/index.cfm. Accessed August 15, 2019.
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[8] WHO | COP24 Special report: Health & Climate Change. WHO. http://www.who.int/globalchange/publications/COP24-report-health-climate-change/en/. Accessed August 15, 2019.
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[10] Watts N, Amann M, Arnell N, et al. The 2018 report of the Lancet Countdown on health and climate change: shaping the health of nations for centuries to come. *The Lancet*. 2018;392(10163):2479-2514. doi:10.1016/S0140-6736(18)32594-7
[11] US EPA. What Climate Change Means for Kentucky. Digital Library. https://digital.library.unt.edu/ark:/67531/metadc948843/. Published August 2016. Accessed August 15, 2019.
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[13] Ren, C; Williams, G; Tong, S. Does Particulate Matter Modify the Association between Temperature and Cardiorespiratory Diseases? *Environmental Health Perspectives* 2006; 114(11) https://doi.org/10.1289/ehp.9266
[14] Wellbery C, Sheffield P, Timmireddy K, Sarfaty M, Teherani A, Fallar R. It's Time for Medical Schools to Introduce Climate Change Into Their Curricula. *Academic Medicine*. 2018;93(12):1774. doi:10.1097/ACM.0000000000002368
[15] Call for organizational endorsement. https://climatehealthaction.org/cta/climate-health-equity-policy/. Accessed August 15, 2019.
[16] McCarthy N. America's Most & Least Trusted Professions [Infographic]. Forbes. https://www.forbes.com/sites/niallmccarthy/2019/01/11/americas-most-least-trusted-professions-infographic/. Accessed August 15, 2019.

## RELEVANT AMA POLICY

### Global Climate Change and Human Health H-135.938

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment.

### Climate Change Education Across the Medical Education Continuum H-135.919

(1) supports teaching on climate change in undergraduate, graduate, and continuing medical education such that trainees and practicing physicians acquire a basic knowledge of the science of climate change, can describe the risks that climate change poses to human health, and counsel patients on how to protect themselves from the health risks posed by climate change; (2) will make available a prototype presentation and lecture notes on the intersection of climate change and health for use in undergraduate, graduate, and continuing medical education; and (3) will communicate this policy to the appropriate accrediting organizations such as the Commission on Osteopathic College Accreditation and the Liaison Committee on Medical Education.

# RESOLUTION

Subject: Climate Change

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, climate change impacts physical, mental and community health; and

WHEREAS, the World Health Organization has described climate change as the greatest threat to global health in the 21st century in a dispatch for immediate action; and

WHEREAS, climate change contributes to heat related illness, respiratory distress and increased exposure to water borne and vector borne illnesses, contributes to stress related disorders and increased social instability; and

WHEREAS, research indicates extreme weather events, storms, flooding, droughts, heat waves are likely to become more frequent and more intense; now, therefore, be it

RESOLVED, that the Kentucky Medical Association develop a climate change policy and consider establishing a work group to make recommendations on strategies for educating members and the public on the medical and health care aspects of climate change; and be it further

RESOLVED, that the KMA report on ways members and the organization can contribute to impacting climate change health outcomes.

RESOLUTION

Subject: Regulation of the Marketing, Packaging, and Sale of Electronic Cigarettes in Kentucky

Submitted by: Katherine Whitehouse, Brooke Barrow, Rachel Safeek, MPH (University of Louisville School of Medicine), Alexander Thebert, Bill Jessee, Kaitlyn Kasemodel, Pat Osterhaus, Sarah Thomas, Nicholas White, Douglas Hayden Wilson (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, an electronic cigarette (e-cigarette) is a disposable or reusable device that operates by heating a liquid solution to create an aerosol that is inhaled, and can come in a variety of designs, resembling regular cigarettes, cigars, pipes, pens, and USB flash drives[1]; and

WHEREAS, e-cigarette use among teens is on the rise across the United States, with the number of teen e-cigarette users increasing by nearly 1.5 million from 2017 to 2018[2]; and

WHEREAS, the rates of e-cigarette use among Kentucky youth exceeds the national average, and use among Kentucky middle and high school students has nearly doubled from 2016 to 2018[3,4]; and

WHEREAS, 43 percent of young adults who tried e-cigarettes reported that they first tried them because of their appealing flavors[4], including cotton candy, gummi bear, mango, cucumber[4]; and

WHEREAS, it is estimated that nicotine levels found in the e-cigarette brand JUUL are equivalent to 20 times that of other electronic and traditional cigarettes, and the product labels sometimes do not list the true nicotine content[5]; and

WHEREAS, the brain does not fully develop until mid to late 20's, thus young adults are at increased risk of harm from nicotine, as it impairs adolescent brain development and can cause long-lasting effects, including impulsivity and mood disorder[2,4]; and

WHEREAS, the aerosol in e-cigarettes contain chemicals, such as formaldehyde and acrolein that can cause irreversible lung damage and have been associated with cancer, lung disease, airway irritation, and heart disease[6,7], and at least 10 chemicals identified in e-cigarettes are on the list of carcinogens and reproductive toxins from the Safe Drinking Water and Toxic Enforcement Act of 1986[5,8]; and

WHEREAS, e-cigarette aerosol has a higher concentration of ultrafine particles than that in conventional tobacco cigarette smoke, and exposure to these particles can worsen respiratory illnesses like asthma and constrict arteries, causing cardiovascular effects such as myocardial infarction[8]; and

WHEREAS, the US Surgeon General concluded in 2016 that second-hand smoke from e-cigarette aerosol contains volatile organic compounds, heavy metals, and flavorings such as diacetyl, all of which are associated with negative health consequences[9]; and

WHEREAS, smoke-free laws are designed to reduce second-hand smoke harm but also have been shown to reduce smoking, increase the success of smoking cessation, and may decrease smoking initiation in youth[10]; and

WHEREAS, in 2016, nearly 4 out of 5 middle and high school students and over 20 million young adults reported that they saw at least one e-cigarette advertisement during the year[11]; and

WHEREAS, e-cigarettes are often marketed as an alternative to smoking cigarettes; however, 40% of users aged 18-24 had never been regular cigarette smokers and the use of e-cigarettes increase the risk of using traditional cigarettes[2,9,4]; and

WHEREAS, few restrictions regarding e-cigarette marketing exist, allowing companies to promote their products through traditional and modern outlets (including radio, television, magazines and social media) that target adolescent audiences[11]; and

WHEREAS, tobacco advertising bans showed a reduction in tobacco use and initiation, especially among the youth[12]; and

WHEREAS, increasing the price of tobacco products has been shown to decrease tobacco consumption and reduce initiation of tobacco use[13,14]; and

WHEREAS, smoking-related health care costs in Kentucky are approaching $2 billion per year[15]; and

WHEREAS, at the time of this resolution's submission, there are no regulations or excise taxes in place on the sale, packaging, and advertising of e-cigarettes in Kentucky[16]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports regulation of marketing and packaging of e-cigarettes, in a way that mirrors the regulation of traditional cigarettes; and be it further,

RESOLVED, that the Kentucky Medical Association supports a ban on e-cigarette use in locations where tobacco use is prohibited; and be it further,

RESOLVED, that the Kentucky Medical Association supports the extension of laws prohibiting tobacco advertising to e-cigarettes; and be it further,

RESOLVED, that the Kentucky Medical Association supports an excise tax on e-cigarettes and liquid solutions.

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**RELEVANT AMA POLICY**

## Electronic Cigarettes, Vaping, and Health H-495.972

1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly.
2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes; (b) supports education of the public on the health effects, including toxins and carcinogens of electronic nicotine delivery systems (ENDS) including e-cigarettes; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction.
3. Our AMA supports legislation and associated initiatives and will work in coordination with the Surgeon General to prevent e-cigarettes from reaching youth and young adults through various means, including, but not limited to, CDC research, education and a campaign for preventing and reducing use by youth, young adults and others of e-cigarettes, and combustible and emerging tobacco products.

## Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

(1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21;
(2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine deliverysystems ((ENDS)) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;
(3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;
(4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;
(5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;
(6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;
(7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;
(8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and
(10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

**Tobacco Product Labeling H-495.989**

Our AMA: (1) supports requiring more explicit and effective health warnings, such as graphic warning labels, regarding the use of tobacco (and alcohol) products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco, and ingredients of tobacco products sold in the United States); (2) encourages the Food and Drug Administration, as required under Federal law, to revise its rules to require color graphic warning labels on all cigarette packages depicting the negative health consequences of smoking; (3) supports legislation or regulations that require (a) tobacco companies to accurately label their products, including electronic nicotine delivery systems (ENDS), indicating nicotine content in easily understandable and meaningful terms that have plausible biological significance; (b) picture-based warning labels on tobacco products produced in, sold in, or exported from the United States; (c) an increase in the size of warning labels to include the statement that smoking is ADDICTIVE and may result in DEATH; and (d) all advertisements for cigarettes and each pack of cigarettes to carry a legible, boxed warning such as: "Warning: Cigarette Smoking causes CANCER OF THE MOUTH, LARYNX, AND LUNG, is a major cause of HEART DISEASE AND EMPHYSEMA, is ADDICTIVE, and may result in DEATH. Infants and children living with smokers have an increased risk of respiratory infections and cancer;" (4) urges the Congress to require that: (a) warning labels on cigarette packs should appear on the front and the back and occupy twenty-five percent of the total surface area on each side and be set out in black-and-white block; (b) in the case of cigarette advertisements, warning labels of cigarette packs should be moved to the top of the ad and should be enlarged to twenty-five percent of total ad space; and (c) warning labels following these specifications should be included on cigarette packs of U.S. companies being distributed for sale in foreign markets; and (5) supports requiring warning labels on all ENDS products, starting with the warning that nicotine is addictive.

**Tobacco Advertising and Media H-495.984**

(1) in keeping with its long-standing objective of protecting the health of the public, strongly supports a statutory ban on all advertising and promotion of tobacco products;

(2) as an interim step toward a complete ban on tobacco advertising, supports the restriction of tobacco advertising to a "generic" style, which allows only black-and-white advertisements in a standard typeface without cartoons, logos, illustrations, photographs, graphics or other colors;

(3) (a) recognizes and condemns the targeting of advertisements for cigarettes and other tobacco products toward children, minorities, and women as representing a serious health hazard; (b) calls for the curtailment of such marketing tactics; and (c) advocates comprehensive legislation to prevent tobacco companies or other companies promoting look-alike products designed to appeal to children from targeting the youth of America with their strategic marketing programs;

(4) supports the concept of free advertising space for anti-tobacco public service advertisements and the use of counter-advertising approved by the health community on government-owned property where tobacco ads are posted;

(5) (a) supports petitioning appropriate government agencies to exercise their regulatory authority to prohibit advertising that falsely promotes the alleged benefits and pleasures of smoking as well worth the risks to health and life; and (b) supports restrictions on the format and content of tobacco advertising substantially comparable to those that apply by law to prescription drug advertising;

(6) publicly commends those publications that have refused to accept cigarette advertisements and supports publishing annually, via JAMA and other appropriate publications, a list of those magazines

that have voluntarily chosen to decline tobacco ads, and circulation of a list of those publications to every AMA member;

(7) urges physicians to mark the covers of magazines in the waiting area that contain tobacco advertising with a disclaimer saying that the physician does not support the use of any tobacco products and encourages physicians to substitute magazines without tobacco ads for those with tobacco ads in their office reception areas;

(8) urges state, county, and specialty societies to discontinue selling or providing mailing lists of their members to magazine subscription companies that offer magazines containing tobacco advertising;

(9) encourages state and county medical societies to recognize and express appreciation to any broadcasting company in their area that voluntarily declines to accept tobacco advertising of any kind;

(10) urges the 100 most widely circulating newspapers and the 100 most widely circulating magazines in the country that have not already done so to refuse to accept tobacco product advertisements, and continues to support efforts by physicians and the public, including the use of written correspondence, to persuade those media that accept tobacco product advertising to refuse such advertising;

(11) (a) supports efforts to ensure that sports promoters stop accepting tobacco companies as sponsors; (b) opposes the practice of using athletes to endorse tobacco products and encourages voluntary cessation of this practice; and (c) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products;

(12) will communicate to the organizations that represent professional and amateur sports figures that the use of all tobacco products while performing or coaching in a public athletic event is unacceptable. Tobacco use by role models sabotages the work of physicians, educators, and public health experts who have striven to control the epidemic of tobacco-related disease;

(13) (a) encourages the entertainment industry, including movies, videos, and professional sporting events, to stop portraying the use of tobacco products as glamorous and sophisticated and to continue to de-emphasize the role of smoking on television and in the movies; (b) will aggressively lobby appropriate entertainment, sports, and fashion industry executives, the media and related trade associations to cease the use of tobacco products, trademarks and logos in their activities, productions, advertisements, and media accessible to minors; and (c) advocates comprehensive legislation to prevent tobacco companies from targeting the youth of America with their strategic marketing programs; and

(14) encourages the motion picture industry to apply an "R" rating to all new films depicting cigarette smoking and other tobacco use.

**Tobacco Prevention and Youth H-490.914**

(1) (a) urges the medical community, related groups, educational institutions, and government agencies to demonstrate more effectively the health hazards inherent in the use of tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco); (b) encourages state and local medical societies to actively advise municipalities and school districts against use of health education

material sponsored or distributed by the tobacco industry; and (c) publicly rejects the tobacco industry as a credible source of health education material;
(2) opposes the use of tobacco products of any kind in day care centers or other establishments where pre-school children attend for educational or child care purposes;
(3) advises public and private schools about the very early smoking habits observed in children and encourages appropriate school authorities to prohibit the use of all tobacco products in elementary through senior high school by anyone during the school day and during other school-related activities;
(4) (a) supports the concept that a comprehensive health education program stressing health maintenance be part of the required curriculum through 12th grade to: (i) help pre-teens, adolescents, and young adults avoid the use of tobacco products, including smokeless tobacco; and (ii) emphasize the benefits of remaining free of the use of tobacco products; (b) will work with other public and private parties to actively identify and promote tobacco prevention programs for minors and encourages the development, evaluation, and incorporation of appropriate intervention programs, including smoking cessation programs, that are tailored to the needs of children; and (c) recommends that student councils and student leaders be encouraged to join in an anti-smoking campaign.
(5) urges state medical societies to promote the use of appropriate educational films and educational programs that reduce tobacco use by young people;
(6) (a) favors providing financial support to promising behavioral research into why people, especially youth, begin smoking, why they continue, and why and how they quit; (b) encourages research into further reducing the risks of cigarette smoking; and (c) continues to support research and education programs, funded through general revenues and private sources, that are concerned with health problems associated with tobacco and alcohol use;
(7) opposes the practice of tobacco companies using the names and distinctive hallmarks of well-known organizations and celebrities, such as fashion designers, in marketing their products, as youth are particularly susceptible;
(8) supports working with appropriate organizations to develop a list of physicians and others recommended as speakers for local radio and television to discuss the harmful effects of tobacco usage and to advocate a tobacco-free society; and
(9) commends the following entities for their exemplary efforts to inform the Congress, state legislatures, education officials and the public of the health hazards of tobacco use: American Cancer Society, American Lung Association, American Heart Association, Action on Smoking and Health, Inc., Groups Against Smoker's Pollution, National Congress of Parents and Teachers, National Cancer Institute, and National Clearinghouse on Smoking (HEW).

**FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973**

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and (3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate

nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

**RELEVANT KMA POLICY**

**1) Access to Tobacco by Children:** KMA is to use every means at its disposal to support legislation that would contain the following elements:
A. Opposition to the use of billboards or other mediums which advertise tobacco products visible from school property (K-12);
B. Tobacco vending machine usage be restricted to persons over 18 years of age;
C. In those areas where free smoking cessation clinics are unavailable, local health departments make available free smoking cessation clinics to children under the age of 18; and
D. No person, except adult employees of the school system who smoke in a designated room for that purpose, shall smoke on school property during school hours; outside sporting events are excluded. (Res E as amended, 1991 HOD, p 652; Reaffirmed, Special Report on Policy Sunset, 2001 HOD, p 578; Reaffirmed 2011)
KMA supports increased fines for those who sell tobacco to minors. (Res 2009-10, 2009 HOD, p 533)
KMA supports penalties on the unlawful sale of tobacco products on the Internet to minors. (Res 2003-12, 2003 HOD, p 617; Reaffirmed 2013)
KMA supports the 100% Tobacco-Free School Campaign calling for all school districts to prohibit tobacco use by staff, students, and visitors 24 hours a day, seven days a week, inside school board-owned buildings or vehicles, on school-owned property, and during school-sponsored student trips and activities. (Res 2010-06, 2010 HOD, p 422)

**2) Deleterious Effects of Tobacco Use:** KMA encourages physicians to continue educational efforts directed to patients on the deleterious effects of tobacco use and encourages the Kentucky General Assembly to increase its attention to the serious health problem of tobacco product use and the trend of teenage smoking. (Res D, 1992 HOD, p 648; Amended and Reaffirmed, Special Report on Policy Sunset, 2002 HOD, p 576; Reaffirmed 2012)
**3) Excise Tax:**
A. New revenues raised by increasing tobacco excise taxes should be applied to Kentucky Medicaid. (Res 2002-116, p 597; Reaffirmed 2012)
B. KMA supports a substantial increase in the cigarette tax with additional revenues generated to be used to fund health-related initiatives including, but not limited to, tobacco cessation, expansion of insurance coverage for children, nutritional supplements for dialysis patients, and the colon cancer screening and treatment program. (Res 2008-14, 2008 HOD, p 625, Reaffirmed 2018)
C. KMA seeks introduction and passage of legislation to increase the Kentucky state tax on all forms of smokeless tobacco to at least the national average. (Res 2013-09, 2013 HOD, p 384)

**4) FDA Regulations:** KMA does not support the use of tax dollars to finance efforts, including lawsuits, aimed at overturning or postponing FDA regulations regarding tobacco. (Res 96-122, 1996 HOD, p 599; Reaffirmed 2006, 2016)

**5) Legal Minimum Age:** KMA supports legislation that increases the legal minimum sale age for tobacco in Kentucky to 21. (Report of Community & Rural Health Committee, 2004 HOD, p 627; Reaffirmed 2014)

**6) Sale of Tobacco:** KMA reaffirms support for local municipalities and counties to adopt more stringent laws and regulations governing the sale and use of tobacco in local facilities; that smoking restrictions in state facilities used by the public in local communities be governed by the same local laws or regulations affecting other local businesses and privately owned facilities. KMA continues to support both additional state taxation on tobacco products to discourage use of tobacco products by minors and public funding of the development of agricultural alternatives to growing and processing of tobacco and tobacco products. (Res 97-135, 1997 HOD, p 578; Reaffirmed 2007, 2009)

**7) Secondhand Smoke:** KMA supports prohibition of smoking in public places including restaurants, bars, hospital campuses and in motor vehicles with children and encourages physicians to counsel patients about the health risks attributed to exposure to secondhand smoke. (Res 2007-06, 2007 HOD, p 664; Reaffirmed 2017)

KMA works with others to increase awareness of the dangers of radon and secondhand smoke as a health risk to Kentuckians. (Res 2010-05, 2010 HOD, p 422)

**8) Statewide Ban on Smoking:** Any statewide ban on smoking that KMA supports would not preempt local initiatives. (Res 2009-10, 2009 HOD, p 533)

**9) Tobacco Use Prevention and Cessation Program:** KMA endorses the efforts of the Kentucky Department for Public Health to prevent and reduce the use of tobacco products in Kentucky. (Res 2001-121, 2001 HOD, p 622; Reaffirmed 2009)

**10) Workplace Wellness Smoking Cessation Incentives:** KMA supports legislation to create an exemption to state law allowing employers to offer workplace wellness smoking cessation incentive programs. (Res 2009-05, 2009 HOD, p 533)

RESOLUTION

Subject: Support for the Establishment of a State Program for Wholesale Importation of Prescription Drugs

Submitted by: Alexander Thebert, Mia Macdonald, Patrick Osterhaus (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, seven of the eight top-selling drugs in the United States cost more than in countries abroad, even after pharmaceutical company discounts[1]; and

WHEREAS, 70% of the top-selling brand name drugs are manufactured outside the country, and are sold for up to 87% less in Canada and 97% less in other countries[2]; and

WHEREAS, in 2016, an estimated 45 million Americans did not fill a prescription due to the cost of pharmaceuticals[3]; and

WHEREAS, Kentucky ranks first in number of retail prescription drugs filled at pharmacies and has the second highest per capita spending on prescription drugs[4,5]; and

WHEREAS, to pay for drugs, Medicaid programs takes the lowest price negotiated by private payers and states can further negotiate, however due to federal laws they are limited in that capacity[6,7]; and

WHEREAS, Kentucky Medicaid spending has been increasing over the past several years and pharmacy costs are the fastest growing budget items[6]; and

WHEREAS, a 2016 poll from Kaiser Family Foundation found that 8% of respondents, or someone in their household, have imported a drug in the past, despite it being illegal in most circumstances[8,9,10]; and

WHEREAS, the major risk associated with importing drugs from other countries comes from purchasing them online, where the suppliers can misrepresent the safety, quality, and licensing of their products[11]; and

WHEREAS, a wholesale importation program is a state-administered “program where the State is the licensed wholesaler, importing drugs from a licensed, regulated Canadian supplier, solely for distribution to voluntarily participating, state-licensed, in-state, pharmacies and administering providers for the exclusive purpose of dispensing to state residents with a valid prescription.”[12]; and

WHEREAS, all the suppliers would be FDA approved and therefore consumers in Kentucky would not be at risk of substandard or fake drugs[12]; and

WHEREAS, the Federal Food, Drug, and Cosmetic Act allows for importation of drugs as long as safety and consumer savings are guaranteed[13]; and

WHEREAS, wholesale importation programs have bipartisan support and a 2019 Kaiser Family Foundation poll put public support for drug importation at 70%[14,15,16]; and

WHEREAS, multiple states have pending legislation for prescription drug importation and Vermont has passed legislation for an importation program with an estimated savings of between $1-5 million dollars for commercial insurers[14,17]; and

WHEREAS, a wholesale importation program as defined above would fit AMA policy D-100.983 regarding importing pharmaceuticals; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support a program for the wholesale importation of pharmaceutical drugs in the Commonwealth of Kentucky.

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**RELEVANT AMA POLICY**

**Policy D-100.983**

(1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported;
(2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured;
(3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation;
(4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts;
(5) support the in-person purchase and importation of Health Canada-approved prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity;
(6) advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured; and
(7) support the personal importation of prescription drugs only if: (a) patient safety can be assured; (b) product quality, authenticity and integrity can be assured; (c) prescription drug products are subject to reliable, “electronic” track and trace technology; and (d) prescription drug products are obtained directly from a licensed foreign pharmacy, located in a country that has statutory and/or regulatory standards for the approval and sale of prescription drugs that are comparable to the standards in the United States.

**Policy H-110.987**

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a

drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

**RELEVANT KMA POLICY**

**Res 2016-9, 2016 HOD**

8) Prescription Drug Cost:
KMA seeks opportunities to advocate for more affordable prescription medications.

KMA, in cooperation with other key stakeholders (e.g. the Kentucky Pharmacists Association, the Kentucky

Nurses Association, and the Kentucky Hospital Association), urge the Pharmaceutical Research and

Manufacturers of America® and its member companies to reign in the cost of medications.

KMA educates state legislators and the state's congressional delegation on the severity and importance of rising prescription drug costs so that lawmakers can more effectively address the problem on behalf of Kentucky citizens.
KMA urges state policymakers to evaluate drug pricing and value to assess possible benefits for patients and physicians. (*Res 2016-9, 2016 HOD*)

# RESOLUTION

Subject: Preventing Medication Assisted Treatment Facilities from Opening in High Populated Areas and Around Churches, Schools, Playgrounds, and Areas Where Children Play

Submitted by: Bell County Medical Society

Referred to: Reference Committee

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WHEREAS, the opiate crisis in Kentucky is a widespread problem that affects every community and nearly every family in Kentucky; and

WHEREAS, there are many treatment options available for drug treatment including behavioral and pharmacological, 12 step programs inpatient and outpatient rehab, as well as medical assisted treatment programs (MAT); and

WHEREAS, the overall success treatment rates for any type of treatment is dismally low in the US including treatment using methadone, suboxone, buprenorphine as substitution medication; and

WHEREAS, that currently existing methadone, buprenorphine and suboxone clinics are usually located in areas of high population densities in close proximity to local churches, schools, and areas where children walk and play; and

WHEREAS, these clinics negatively impact the local churches, schools, and neighborhoods by requiring as many as 300 drug addicts visit these clinics daily; and

WHEREAS, it is established that addiction to these drugs are more prevalent near these clinics due to the tremendous distribution of these drugs from a single facility; and

WHEREAS, school age children are frequently sold these medications on the street from addicts in the program; and

WHEREAS, it is the purpose of the KMA to support programs beneficial to not only its members but for the millions of citizens of Kentucky as well as our youth to promote real health choices that helps to eliminate drug addiction; now, therefore, be it

RESOLVED, that the Kentucky Medical Association neither supports the growth of these medical assisted treatment facilities as it is currently structured, and that until further review of the impact MAT clinics create in the communities they are located in, the KMA does not support further growth and expansion of these and that the KMA recommends these clinics be at least confined to the more rural or lessor populated areas within our state.

RESOLUTION

Subject: Preventing Medication Assisted Treatment Facilities from being Owned and Operating within a For-Profit Clinic

Submitted by: Bell County Medical Society

Referred to: Reference Committee

WHEREAS, the opiate crisis in Kentucky is a widespread problem that affects every community and nearly every family in Kentucky; and

WHEREAS, drug distribution in the US has been an extremely profitable business, both through illegal as well as legal entities where revenue and profits are one of the most lucrative businesses in the US; and

WHEREAS, that Medical Assisted Treatment (MAT) centers have operated at high profit levels for the owners and operators of these clinics; and

WHEREAS, privately owned MAT clinics have been criticized for lacking in controls and regulatory processes; and

WHEREAS, communities where MAT clinics are located have reported a higher level of drug addiction to the types of drugs used by these clinics; and

WHEREAS, that non- profit centers and government controlled operations have better means of controlling the qualifications of those who enter the program as well as insuring that all drugs dispensed meet critical guidelines by removing the incentive to over treat and over prescribe; and

WHEREAS, there are many clinics operating effectively via universities and other non-profit organizations where the incentive to over prescribe is more heavily regulated; and

WHEREAS, Kentucky must do everything possible to control unnecessary distribution of drugs; now, therefore, be it

RESOLVED, that the Kentucky Medical Association (KMA) feels that no doctor, nurse practitioner, clinic, dentist, administrators or owners of Medical Assisted Treatment (MAT) clinics should profit directly from prescribing opiates including methadone, suboxone, and buprenorphine and that these clinics must be owned and operated independently from those who actually prescribe the medication. Such an example would be ownership by the state of Kentucky or within public universities where all the stakeholders are salaried and not rewarded with incentives or profit sharing. The KMA also recognizes that these newly reorganized MAT centers will be very busy due to their exclusivity and restricted service centers, and that all profits beyond the

operating budget be placed in a special account earmarked for enhancing rehabilitation, education, and law enforcement for reducing drug addiction.

RESOLUTION

Subject: Affirming the Mental Health Parity and Addiction Equity Act is Federal Law and Insurers and Providers Must Abide by the Law with Enforcement from the State

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

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WHEREAS, about 19.9 million adults needed substance use treatment in 2016, representing 8.1 percent of adults, and of the 19.9 million adults needing substance use treatment, only 10.8 percent received specialty treatment; and

WHEREAS, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act passed in 2008 to end discriminatory healthcare practices against those with mental illness and/or addiction; and

WHEREAS, insurers may not be complying with some components of the law, albeit unintentionally, which violates the federal parity statute and can lead to deaths from suicides, overdoses and other forms of preventable death by inappropriately limiting access to care; and

WHEREAS, many states have already moved to enact legislation to provide transparency and accountability for mental health and substance use disorder; and

WHEREAS, states have primary enforcement authority over insurers that sell health insurance policies in their states and can protect consumers with Substance Use Disorders to ensure they are able to access substance use treatment by mitigating violations of the federal parity statute regarding cost and availability; now, therefore, be it

RESOLVED, that the Kentucky Medical Association requests the state Department of Insurance and Commissioner to take action to determine if insurers are in compliance with the federal parity law through primary enforcement authority including establishing reporting requirements for insurers to demonstrate how they design and apply their managed care tactics; and be it further

RESOLVED, the KMA request the state Department of Insurance and Commissioner perform market conduct examinations of insurers and use of nonquantitative treatment limitations when addressing the matters of pre-existing conditions, length of treatment, insurance coverage, dosage limitations, network adequacy, and requirements for counseling frequency based on patient history and need; and be it further

RESOLVED, that the KMA support federal efforts to achieve mental health parity compliance through federal legislation and regulation.

RESOLUTION

Subject: Substance Use Disorder Treatment in Correctional Facilities

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS substance use disorders (SUD) represent a chronic medical condition associated with significant morbidity and mortality, as well as substantial public health, economic, and social impacts; and

WHEREAS, although SUDs and criminal behavior are frequently linked, offenders are often not provided adequate treatment for their SUDs, leading to significant medical and psychiatric morbidity, increased risk of non-fatal and fatal overdose, and chronic enmeshment in a costly cycle of criminal justice system engagement[1]; and

WHEREAS, SUD treatment for criminal justice-involved individuals is efficacious, promotes recovery, decreases risk of transmission of communicable infectious diseases, and fosters productive reintegration back into society after release[2]; and

WHEREAS, in 2016, the Rhode Island Department of Corrections initiated medication-assisted treatment (MAT) for justice-involved individuals with opioid use disorder (OUD), ultimately leading to a 60.5% decrease in mortality in this population[3]; and

WHEREAS, the American Academy of Addiction Psychiatry (AAAP) asserts that diversion to SUD treatment programs is preferable to incarceration for non-violent offenders, as it improves outcomes and is less costly to society than incarceration[4]; and

WHEREAS, the AAAP, American Correctional Association, and the American Society of Addiction Medicine assert that inmates of jails and prisons who are mandated to confinement should be screened for SUDs and co-morbid psychiatric conditions, receive the full range evidence-based multimodal treatment for SUDs (including MAT for OUD), and supplied with provisions for easily accessible treatment after release [4,5]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association advocate that Kentucky correctional facilities provide all inmates screening for substance use disorders and co-morbid psychiatric conditions to identify inmates who would be candidates for treatment; and be it further

RESOLVED, that the Kentucky Medical Association advocate that Kentucky correctional facilities provide inmates evidence-based treatment for substance use disorders and co-morbid psychiatric conditions, including evidence-based pharmacotherapy for opioid use disorder; and be it further

RESOLVED, that the KMA support and include all three FDA approved pharmacotherapies.

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RESOLUTION

Subject: Mitigate Criminal Legal Barriers Which are Preventing Kentuckians Who are Struggling with Substance Use Disorder (SUD) from Acquiring Gainful Employment

Submitted by: Lexington Medical Society

Referred to: Reference Committee

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WHEREAS, 1,600 Kentuckians died from opioid-related overdoses in 2017 (Office of Vital Statistics), a rise of 117% in heroin and 564% in fentanyl from 2012-2017; and

WHEREAS, treating the opioid epidemic criminally has not yielded acceptable results; and

WHEREAS, possession of heroin, fentanyl or other scheduled drugs in Kentucky is a Class D felony which may lead to imprisonment of 1-3 years; and

WHEREAS, Kentucky incarceration rates for Class D felony related offenses have soared between 2012-2016, offenders jailed for drug possession rose from 911 in 2012 to 1,836 in 2016; and

WHEREAS, cost to incarcerate a state inmate in Kentucky is $18,406 per year, and the cost to taxpayers in 2016 to imprison offenders for drug offenses was $82 million; and

WHEREAS, Princeton economist, Alan Krueger, published in 2017, a strong link between rising opioid prescriptions and declining workforce participation rates, citing half of men age 25-54 who were not in the workforce were taking pain medications daily; and

WHEREAS, Kentucky Chamber of Commerce on workforce participation in a 2017 report found Kentucky had one of the lowest workforce participation rates in the country, citing contributing factors to include high levels of disability, poverty and low education, incarceration, and substance abuse; and

WHEREAS, Kentucky employers are struggling to fill available jobs; but employers are reluctant to hire someone in recovery due to their criminal background and the negative stigma associated with addiction; and

WHEREAS, Kentucky's approach to solving the opioid crisis criminally has contributed to the tremendous disconnect between Kentucky employers who need to fill jobs and Kentucky residents in recovery who are searching for gainful employment; and

WHEREAS, addicts who are working on recovery need a path back to society that includes gainful employment; and

WHEREAS, without a community willing to accept the recovering population, there is little chance of reintegration back into Kentucky's workforce; and

WHEREAS, encouraging employment of Kentuckians pursuing recovery will give them purpose as they look at life beyond drug abuse, and it will boost workforce participation; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports efforts to mitigate criminal legal barriers which are preventing Kentuckians who are struggling with substance use disorder (SUD) from Acquiring Gainful Employment; and be it further

RESOLVED, that the Kentucky Medical Association joins the Kentucky Chamber of Commerce in promoting legislative changes to lessen penalties for Kentuckians struggling with substance use disorder, downgrading nonviolent, non-trafficking, drug possession charges from felonies to misdemeanors with the requirement that the person undergoes an approved treatment program.

# RESOLUTION

Subject: Nicotine Delivery Device Tax

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

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WHEREAS, the number of youth using electronic nicotine delivery devices has reached epidemic levels, and millions of new individuals with nicotine use disorder (nicotine dependency) are predicted; and

WHEREAS, there are currently no taxes on these sources of nicotine in Kentucky; and

WHEREAS, taxation has been shown to discourage use of combustible cigarettes; now, therefore, be it

RESOLVED, that the Kentucky Medical Association arrange introduction and support legislative statutes to tax electronic nicotine delivery devices (e-cigarettes, JUUL and vaping devices, etc.) and supplies at rates proportional to nicotine levels delivered by conventional, combustible cigarettes; and be it further

RESOLVED, that KMA support application of all revenues so generated to funding Expanded Medicaid in the Kentucky State budget; and be it further

RESOLVED, that KMA create a strong educational program to inform the public, especially youth, of the dangers of using these devices, and so discourage use of such devices by youth.

# RESOLUTION

Subject: National Tort Reform

Submitted by: Lexington Medical Society

Referred to: Reference Committee

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WHEREAS, the shortage of physicians in the United States can be related to the expenses of medical education and medical practice; and

WHEREAS, Kentucky and most other states have physicians with major expenses related to medical liability; and

WHEREAS, Kentucky continues to lose physicians to states which have malpractice damage caps; and

WHEREAS, 30 states have some form of malpractice damage caps, such as caps on pain and suffering, noneconomic damages, and absolute caps; and

WHEREAS, some states, such as Indiana, have a provider liability cap of $250,000, and the former governor of Indiana is currently Vice President of the United States; and

WHEREAS, major changes in tort reform in Kentucky will require a change in the state constitution and a referendum by the people; and

WHEREAS, a national approach to limiting medical liability expenses would be fairer and more consistent to physicians in all states; and

WHEREAS, the state and national political climate would likely support a more consistent approach to medical liability expenses; now, therefore, be it

RESOLVED, that the Kentucky Medical Association formally advocate for a national cap on provider liability and solicit congressional support for such improvement in the medical practice environment.

2019-24

RESOLUTION

Subject: Removing Opposition to a Single-Payer Healthcare System

Submitted by: Sarah Parker, Erik Seroogy, MPH (University of Louisville College of Medicine), Alexander Thebert, Mia MacDonald, Patrick Osterhaus (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, the American Medical Association and World Health Organization both recognize health care as a basic human right and its provision as an ethical obligation of a civil society[1,2]; and

WHEREAS, lack of insurance is associated with higher morbidity and mortality rates, and despite the efforts of the Patient Protection and Affordable Care Act, 27 million Americans remain uninsured[3,4,5,6,7]; and

WHEREAS, the U.S. spends 17.9% of its GDP on health care, double the Organization for Economic Co-operation and Development (OECD) average, and yet has a health system that ranks only 37th in the world, producing higher infant mortality rates, higher disease burden, and a lower life expectancy than other developed nations[8,9,10,11,12,13]; and

WHEREAS, the U.S. spends over 8% of its healthcare dollars on administration, which is 2.5 times the OECD average, more than any other OECD country[14]; and

WHEREAS, narrow provider networks incentivized by the current health insurance system prevent patients from having the freedom to choose their doctors, and employer-based private health insurance restricts patients from having full freedom to choose their insurance plan[15,16,17,18]; and

WHEREAS, due to extensive, pressing problems of our current healthcare system, organized medicine should be open to consideration of all potential solutions, including a single payer system; and

WHEREAS, several independent analyses of federal single-payer legislation have found that the administrative savings and other efficiencies of a single-payer program would provide more than enough resources to provide coverage to everyone in the country with no increase in overall U.S. health spending[19, 20,21,22]; and

WHEREAS, polls have indicated a majority of physicians support single-payer healthcare systems, making the AMA and KMA's position of strong unequivocal opposition not representative[23,24,25,26,27]; and

WHEREAS, there is a significant difference between current proposed forms of nationalized health care plans. (i.e. single payer vs. Medicare for All vs. a public option, etc.) This is a significant point of confusion for physicians and the public[28,29,30]; and

WHEREAS, unequivocal opposition to single-payer healthcare prevents medical societies from being able to evaluate all healthcare proposals objectively; and

WHEREAS, comprehensive health system reform is a priority of the AMA (AMA policy H-165.847) and KMA (p. 26, Medicaid, Section 4); as leaders of the healthcare field, we must remain open to engaging in productive discussions to create a healthcare system that mutually benefits patients and physicians; now, therefore, be it

RESOLVED, that the Kentucky Medical Association revise existing policy to remove opposition to single-payer systems while preserving the principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

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**RELEVANT KMA POLICY:**

**Res Final Reports of BOT & AMA Delegates, 1969 HOD; Reaffirmed 2000, 2010**

National Health Insurance: KMA opposes any form of compulsory national health insurance.

**Res COSLA HOD 1999; Reaffirmed 2009**

Universal Health Insurance Coverage: KMA affirms its support for a pluralistic approach to health care delivery systems and financing mechanisms in achieving universal health insurance coverage. We recommend a plan that provides a standard set of benefits and includes a fee-for-service option. There are a variety of approaches to Universal Coverage, including employer mandate, individual mandate, or Medical Savings Accounts. KMA strongly supports the patient's freedom and responsibility to choose his/her physician, insurance carrier, and health insurance. Nationalized or socialized health care plans, or single payer systems are not in the best interest of the patient, physician, or the nation and should be opposed.

**Res 2008-22, 2008 HOD, p. 620; Reaffirmed 2018**

2) Principles for Reducing the Number of Uninsured Individuals: KMA will consider the following principles when developing or determining policy on initiatives that purport to reduce the number of uninsured:
• Universal access to care and coverage for that care must be made available to citizens through a pluralistic approach
• Efforts to reform healthcare to achieve universal access and coverage should include a physician-centered oversight authority insulated from both political and commercial interests
• Health insurers, health-related manufacturers, and pharmaceutical companies should either make concessions to reduce burdens or receive additional oversight that reduces overhead, maximizes efficiency, and increases the proportion of premium and product dollars that are applied to the delivery of healthcare. Such oversight would mandate that health insurers make public the percentage of premiums used to pay administrative costs and stockholder profit
• Cost effective and medically appropriate resource initiatives for patients, insurers, physicians, non-physicians, and other healthcare-related organizations are imperative
• Regionalizing healthcare to meet a population's health needs is important to eliminate risks specific to the area as well as to provide regions with the ability to determine how health dollars are spent
• Patient choice and preservation of the patient-physician relationship are essential; and
• A progressive financing system should be based on personal responsibility and, in part an individual's ability to pay.

**Res 2017-20, 2017 HOD**

KMA supports the continuation of federal funding for the population covered under Medicaid to ensure that low-income patients are able to secure affordable and adequate coverage.

KMA continues to evaluate various proposals relating to coverage, access, delivery, and economic sustainability of health care in Kentucky.

KMA will advocate for a focus on preventative care as a means to decrease overall health care cost.

KMA supports the American Medical Association Vision on Health Reform as stated in its document of November 15, 2016.

**RELEVANT AMA POLICY:**

**H-165.839 Health Insurance Exchange Authority and Operation**

1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:

A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.

B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.

C) Physician and patient decisions should drive the treatment of individual patients.

D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.

F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.

**H-165.856 Health Insurance Market Regulation**

Our AMA supports the following principles for health insurance market regulation:

(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;

(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;

(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;

(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium;

(5) Insured individuals should be protected by guaranteed renewability;

(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;

(7) Guaranteed issue regulations should be rescinded;

(8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.

(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and

(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:

(a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

**H-165.838 Health System Reform Legislation**

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

a. Health insurance coverage for all Americans

b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps

c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials

d. Investments and incentives for quality improvement and prevention and wellness initiatives

e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

f. Implementation of medical liability reforms to reduce the cost of defensive medicine

g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services

b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system

c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted

d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate

e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another

f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

**H-165.844 Educating the American People About Health System Reform**

Our AMA reaffirms support of pluralism, freedom of enterprise, and strong opposition to a single payer system.

**H-165.847 Comprehensive Health System Reform**

1. Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA. 2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate.

**H-165.881 Expanding Choice in the Private Sector**

Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions

by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients.

**H-165.882 Improving Access for the Uninsured and Underinsured**

Our AMA:

(1) Will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage.

(2) Supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. Any support for such small employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed.

(3) Through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope.

(4) Supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers.

(5) Encourages physicians, through their local county medical societies, to explore ways to work within their communities to address the expanding problem of inadequate access to care for the uninsured and underinsured and openly communicate with one another to share information about successful programs.

(6) Will offer advice or assistance to states in advocating that the Consumer Operated and Oriented Plan (COOP) advisory board and HHS ensure that new insurance issuers, including those with physician involvement, benefit from start-up loans.

(7) Will take action to restore necessary funding for new health insurance co-operatives which had applied prior to enactment of the American Tax Relief Act of 2012, which eliminated this funding, and will work with the National Alliance of State Health Co-Ops (NASHCO) and other stakeholders to request the United States Congress and the US Department of Health and Human Services to re-establish funding to support new health insurance Co-Ops, which had applied prior to the enactment of the American Tax Relief Act of 2012.

**H-165.888 Evaluating Health System Reform Proposals**

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:

A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.

B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.

C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.

D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.

E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.

F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.

G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.

H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.

3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients

**H-165.920 Individual Health Insurance**

Our AMA:

(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;

(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;

(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:

(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;

(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;

(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and

(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;

(4) will identify any further means through which universal coverage and access can be achieved;

(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;

(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;

(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;

(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;

(9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;

(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;

(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;

(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and

(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.

(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution.

**H-185.974 Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs**

Our AMA supports parity of coverage for mental illness, alcoholism and substance use.

**H-165-985 Opposition to Nationalized Health Care**

Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:

(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.

(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. (Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5)

(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.

(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.

(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.

(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.

(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.

**H-185.986 Nondiscrimination in Health Care Benefits**

Our AMA reaffirms its opposition to discriminatory benefit limitations, copayments or deductibles for the treatment of psychiatric illness under existing health care plans and opposes discrimination in any proposed plans for national health care coverage or universal access for the people who are uninsured.

**D-165.936 Updated Study on Health Care Payment Models**

Our AMA will research and analyze the benefits and difficulties of a variety of health care financing models, with consideration of the impact on economic and health outcomes and on health disparities and including information from domestic and

# RESOLUTION

Subject: Association Health Plans
Submitted by: Frank Burns, MD
Referred to: Reference Committee

WHEREAS, Association Health Plans (AHPs), under the Department of Labor's Final Rule, are group health plans that employer groups and associations offer to provide health coverage to employees; and

WHEREAS, the AHP Final Rule allows employers to band together to form associations for the express purpose of offering health coverage if they are either 1) in the same trade, industry, line of business, or profession, or 2) have a principal place of business within a state or metropolitan area, even if the metropolitan area includes more than one state; and

WHEREAS, under the Affordable Care Act (ACA), small businesses of less than 50 employees are not required to offer health insurance to their employees nor are they required to offer health insurance plans that cover all 10 Essential Health Benefits of the ACA; and

WHEREAS, only 55 percent of small businesses with less than 100 employees offer medical benefits to employees; and

WHEREAS, nearly half of all GLMS physician members are in independent practices and many are not able to offer any health insurance benefits to their employees due to the increasing cost of insurance; and

WHEREAS, AHPs can be designed to provide protection against discrimination as they are subject to sections 701 and 702 of ERISA, which prohibit discrimination based on pre-existing conditions and health status; now, therefore, be it

RESOLVED, that the Kentucky Medical Association explore options for their independent small business members to offer health insurance through an Association Health Plan which allows employers to band together to form associations for the express purpose of offering health coverage as long as the plan prohibits discrimination based on pre-existing conditions and health status.

RESOLUTION

Subject: Patient, Physician and Market Protection from Association Health Plan Effects

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, the highly profitable insurance industry product, Association Health Plans (AHP)(aka Multiple Employer Welfare Arrangements, originally limited to small businesses) are being more broadly promoted , but are strongly opposed by the American Medical Association, American Osteopathic Association, American Academy of Family Physicians, American College of Physicians and other physician or consumer advocacy groups, based on Essential Benefit omissions, coverage caps, discrimination, surprise billings, misrepresentation & fraud, market distortions, insolvency risks and other faults; and

WHEREAS, Essential Benefits omitted most frequently include [% omitted bracketed]: maternity care [100%], mental health care [43%], substance abuse treatment [62%] and outpatient prescription drugs [71%] (in 45 states analyzed by Kaiser Family Foundation in 2018); and

WHEREAS, AHP regulations were substantially restructured by Executive Order of President Trump on 10/12/17 and 2018 Final Rule, including expanded deployment and revoking 3-month duration limits to allow indefinite renewals, which will vastly expand AHP use and harm from benefit limitations; and

WHEREAS, it is unclear if this Federal Executive Order and Final Rule overrides ability of states to protect their citizens and providers with remedies to these AHP faults; now, therefore, be it

RESOLVED, that the Kentucky Medical Association obtain legal opinion to determine whether or not State legislation could protect KY patients, physicians and State insurance markets from the harmful effects of AHPs, or any similar limited-benefit plans, after the Presidential Executive Order of 10/12/17 and 2018 Final Rule, and to advance such legislation in Kentucky, if legally appropriate; and be it further

RESOLVED, that that the KMA request the AMA to develop and legislatively advance programs that allow small businesses to provide their employees with health insurance that is both comprehensive (45 CFR 156 compliant) and affordable, including options for Exchange Policies that receive graduated tax credits or increased deductions scaled according to resources and profitability of the small business.

# RESOLUTION

Subject: Requiring Workers Compensation Companies to Develop Processes for Electronic Prior Authorization

Submitted by: Bell County Medical Society

Referred to: Reference Committee

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WHEREAS, Kentucky Workers Compensation have existed in this state for many years; and

WHEREAS, these companies have slashed workers compensation benefits to insured employees, deny coverage in many instances for needed medical care, and have shifted the cost of workplace accidents to taxpayers by directly denying car for legitimate work related claims; and

WHEREAS, many reviews as well as denials are determined by non-specialist physicians, nurse practitioners, physician assistants, and out of state physicians not licensed in Kentucky; and

WHEREAS, it is a common practice that critical care is frequently delayed by over one month for “review” by worker compensation companies; and

WHEREAS, similar problems have recently been addressed in the Kentucky Legislature in 2019 under Senate Bill 54 and signed by the Governor mandating among other requirements that “insurers develop processes for electronic prior authorizations, to establish an extended length of authorization under certain circumstances” and meet electronic prescribing prior authorization; now, therefore, be it

RESOLVED, that the Kentucky Medical Association requests the same requirements that are in place for private insurances be mandated for workers compensation companies and that prior authorization be determined on-line with preset objective criteria, and that any disputes be handled with Kentucky licensed physicians with the same specialty as the treating physician.

# RESOLUTION

Subject: Status of Physician Provider Tax Proposal

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

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WHEREAS, in 2018, an organization of hospital executives (Balanced Health Kentucky) proposed enacting a physician provider tax to fund Kentucky Expanded Medicaid, which could potentially be introduced in the 2020 KY legislative session (a budgetary year); and

WHEREAS, KMA policy opposes such a tax; now, therefore, be it

RESOLVED, that the Kentucky Medical Association determine the status of the hospital executive organization (Balanced Health Kentucky) proposal to enact a physician provider tax for funding Kentucky Expanded Medicaid, or any similar provider tax proposal, and report the findings to the KMA House of Delegates.

RESOLUTION

Subject: Support for the Equality Act

Submitted by: Greater Louisville Medical Society

Referred to: Reference Committee

WHEREAS, there already exist federal civil rights laws protecting individuals from discrimination based on race, color, religion, sex, national origin, and disability; and

WHEREAS, discrimination based upon sexual orientation and gender identity is still legal in the majority of places in the U.S., leaving Lesbian, Gay, Bisexual, Transgender, and Queer (LGBTQ) individuals without equal protection under the law; and

WHEREAS, only 21 states explicitly protect LGBTQ individuals from discrimination, which means that individuals are vulnerable to being fired from a job, evicted from their home, or being otherwise discriminated against simply because of their immutable identity; and

WHEREAS, it is well documented that LGBTQ populations have poorer health outcomes due in part to discrimination, which often enters healthcare settings; and

WHEREAS, the AMA, American Academy of Family Physicians (AAFP), and other leading medical organizations have policies that oppose discrimination based on sexual orientation and gender identity; and

WHEREAS, many Kentuckians, including Kentuckians in the medical profession and the patients we serve, identify as LGBTQ and are thus directly affected by discrimination; and

WHEREAS, the Equality Act (HR5), a bill first introduced in 2015 and re-introduced in 2019, would add sexual orientation and gender identity to the federal Civil Rights Act, prohibiting discrimination on the basis of sexual orientation and gender identity in employment, housing, public education, federal funding, and other institutions; and

WHEREAS, the Equality Act passed the full U.S. House of Representatives in May 2019, but is currently being blocked in the U.S. Senate; and

WHEREAS, Kentucky Senators, Mitch McConnell and Rand Paul, possess considerable power and influence within the U.S. Senate; now, therefore, be it

RESOLVED, that the Kentucky Medical Association write a letter of support to U.S. Senators from Kentucky in favor of passing the Equality Act; and be it further

RESOLVED, that the KMA oppose discrimination on the basis of race, color, religion, national origin, disability, sex, sexual orientation, and gender identity.

RESOLUTION

Subject: J-1 Visa Waiver Program

Submitted by: Northern Kentucky Medical Association, Greater Louisville Medical Society, Ralph Alvarado, MD

Referred to: Reference Committee

WHEREAS, we are now experiencing a physician shortage in Kentucky and nationally; and

WHEREAS, Kentucky ranks 40th among the United States in its primary care physician workforce per 100,000 people, with 2,696 practicing primary care physicians statewide; and

WHEREAS, in order to not worsen its PC physician shortage, Kentucky would have to add 119 primary care physicians per year, bringing their total number in Kentucky to approximately 3,208 in the year 2025; and

WHEREAS, we have a large group of international medical graduates currently working in the united states including Kentucky waiting years to obtain a permanent work visa; and

WHEREAS, without a permanent work visa they are subject to deportation further aggravating our work force deficit; and

WHEREAS, Kentucky Cabinet for Health and Family Services offers J-1 Visa Waiver programs in the Health Care Access Branch to assist the public and private health sectors in qualifying to employ an international medical graduate who may obtain a waiver of his or her two-year home residency requirement by serving in a health professional shortage area or medically underserved area/population for a period of three years; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support federal and state legislation to support a revision of immigration policy to expedite the immigration process for international medical graduate physicians.

References

[1] https://ruralhealth.med.uky.edu/sites/default/files/Kentuckys%20Primary%20Care%20Workforce%20Shortages.pdf
2 https://chfs.ky.gov/agencies/dph/dpqi/hcab/Pages/j1visawaiver.aspx

RESOLUTION

Subject: Pediatric Cancer Research Funding

Submitted by: McCracken County Medical Society

Referred to: Reference Committee

WHEREAS, childhood cancer is the leading cause of death by disease in children; and

WHEREAS, 1 in 285 children in the United States will be diagnosed by their 20th birthday; and

WHEREAS, 43 children per day or 15,780 children are diagnosed with cancer annually in the U.S.; and

WHEREAS, there are approximately 40,000 children on active treatment at any given time; and

WHEREAS, the average age of diagnosis is 6 years old, compared to 66 years for adults' cancer diagnosis; and

WHEREAS, 80% of childhood cancer patients are diagnosed late and with metastatic disease; and

WHEREAS, on average there's been a 0.6 percent increase in incidence per year since the mid 1970's resulting in an overall incidence increase of 24 percent over the last 40 years; and

WHEREAS, two-thirds of childhood cancer patients will have chronic health conditions as a result of their treatment toxicity, with one quarter being classified as severe to life-threatening; and

WHEREAS, approximately one half of childhood cancer families rate the associated financial toxicity due to out-of-pocket expenses as considerable to severe; and

WHEREAS, in the last 20 years only four new drugs have been approved by the FDA to specifically treat childhood cancer compared to more than 185 for adults; and

WHEREAS, the National Cancer Institute recognizes the unique research needs of childhood cancer and the associated need for increased funding to carry this out; and

WHEREAS, federal funding for childhood cancer research represents only about 5% of total cancer research funding, giving states a critical role in overcoming the disparity between adult and childhood cancer research; and

WHEREAS, the Kentucky Cancer Registry has detected an 87% higher incidence of pediatric brain tumors in a 40-county area of Kentucky; and

WHEREAS, the Kentucky Pediatric Cancer Research Trust Fund was established to incentivize collaboration and innovation between the University of Kentucky and University of Louisville for cures with less toxicity for Kentucky children; and

WHEREAS, children diagnosed with cancer also have unique psychosocial needs and action should be taken to implement Psychosocial Standards of Care as part of comprehensive childhood cancer treatment; and

WHEREAS, too many children are affected by this deadly disease and more must be done to raise awareness and find a cure; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports the utilization of state budget appropriations to increase funding of childhood cancer research; and be it further

RESOLVED, in an effort to raise awareness and expand knowledge during the 2020 legislative session, the Kentucky Medical Association, through its communication vehicles, educate physician members and the public regarding the prevalence of childhood cancer in Kentucky and the current lack of necessary funding for childhood cancer research.

RESOLUTION

Subject: Maternal Mortality Rates

Submitted by: Monalisa Tailor, MD

Referred to: Reference Committee

WHEREAS, the United States is the only industrialized country in the world with an increasing maternal mortality rate; and

WHEREAS, the American College of Obstetrics and Gynecology (ACOG) has identified that African American women are four times more likely to die from pregnancy related complications than any other race in the United States[1]; and

WHEREAS, data collected in the state of Kentucky is limited, and focuses on the number of pregnant women and births per county, and not broken down by demographic; and

WHEREAS, information about maternal demographics and outcomes in our state could help improve education and counseling for our patients; now, therefore, be it

RESOLVED, that the Kentucky Medical Association speak with invested partners like the Cabinet for Health and Family Services, the KY Chapter for ACOG, and others to advocate for ways to improve maternal mortality rates in the state of Kentucky in the context of state and federal laws.

References

[1] American College of Obstetricians and Gynecology: Federal Legislative Activities on Maternal Mortality. Last accessed August 4, 2019. https://www.acog.org/About-ACOG/ACOG-Departments/Government-Relations-and-Outreach/Federal-Legislative-Activities/Maternal-Mortality?IsMobileSet=false

RESOLUTION

Subject: Support Legislation Requiring Explicit Consent Before Pelvic Examinations Performed Under Anesthesia

Submitted by: Jessica Geddes, Kaitlyn Kasemodel, Pat Osterhaus, Samantha Ruley, Lincoln Shade, Lexi Sunnenberg, Cody Sutphin (University of Kentucky College of Medicine)

Referred to: Reference Committee

WHEREAS, medical Students in Kentucky are not explicitly barred from performing pelvic exams on anesthetized patients even when the patient has not explicitly consented to the exam and there is no medical indication[1,2]; and

WHEREAS, an Evidence Study conducted by the US Preventive Services Task Force and published by JAMA in 2017 found that there was “limited evidence” regarding the diagnostic accuracy of pelvic examinations in asymptomatic patients[3]; and

WHEREAS, the AMA Council on Ethical and Judicial Affairs, The Association of American Medical Colleges, and the Committee on Ethics of the American College of Obstetricians and Gynecologists (ACOG) have all published statements denouncing the practice of pelvic exams on anesthetized patients when specific informed consent has not been obtained[2]; and

WHEREAS, a 2010 survey of 102 women found that, while a majority (62%) of respondents would consent to medical students doing pelvic examinations if asked, 72% expected to be asked for consent before medical students undertook pelvic examinations under anesthesia, and only 19% were already aware that a medical student might do a pelvic examination in the operating room[4]; and

WHEREAS, eight states (California, Hawaii, Illinois, Iowa, Oregon, Virginia, Utah, and Maryland) have already passed legislation that prohibits unauthorized pelvic examinations, and at least nine other states (Connecticut, Minnesota, Missouri, Nebraska, New Hampshire, New York, Oklahoma, Washington, and Texas) are currently considering similar legislation[5]; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support legislation that would require explicit patient consent before pelvic examinations performed under anesthesia.

References

[1] Kentucky Legislative Research Commission Search
[2] JAMA Forum: Teaching Pelvic Examination Under Anesthesia Without Patient Consent. *JAMA.* January 16, 2019.
[3] Periodic Screening Pelvic Examination: Evidence Report and Systematic Review for the US Preventive Services Task Force *JAMA.* 2017;317(9):954-966
[4] Wainberg S, et al. Teaching pelvic examinations under anaesthesia: what do women think? *J Obstet Gynaecol Can*. 2010;32(1):49-53. doi:10.1016/S1701-2163(16)34404-8
[5] HH. Med Students Are Doing Vaginal Exams on Unconscious, Non-Consenting Patients. *Vice*. June 2019.

## RELEVANT AMA AND KMA POLICY

### Office-Based Surgery Regulation H-475.984

Our AMA supports the following Core Principles on Office-Based Surgery:

- Core Principle #1: Guidelines or regulations for office-based surgery should be developed by states according to levels of anesthesia defined by the American Society of Anesthesiologists (ASA) excluding local anesthesia or minimal sedation. (American Society of Anesthesiologists. Continuum of depth of sedation. Available at: http://www.asahq.org/for-members/standards-guidelines-and-statement.aspx. Accessed July 2, 2013).

- Core Principle #2: Physicians should select patients for office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia by criteria including the ASA Physical Status Classification System and so document. (American Society of Anesthesiologists. ASA physical status classification system. Available at: http://www.asahq.org/for-members/clinical-informaion/asa-physical-status-classification-syst em.aspx. Accessed July 2, 2013).

- Core Principle #3: Physicians who perform office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have their facilities accredited by The Joint Commission, Accreditation Association for Ambulatory Health Care (AAAHC), American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF), American Osteopathic Association (AOA), or by a state recognized entity, such as the Institute for Medical Quality (IMQ), or be state licensed and/or Medicare certified.

- Core Principle #4: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia must have admitting privileges at a nearby hospital, or a transfer agreement with another physician who has admitting privileges at a nearby hospital, or maintain an emergency transfer agreement with a nearby hospital.

- Core Principle #5: States should follow the guidelines outlined by the Federation of State Medical Boards (FSMB) regarding informed consent. (Report of the Special Committee on Outpatient [Office-Based] Surgery. (Med. Licensure Discipline. 2002; 88:-160-174).

- Core Principle #6: For office surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, states should consider legally privileged adverse incident reporting requirements as recommended by the FSMB and accompanied by periodic peer review and a program of Continuous Quality Improvement. (Report of the Special Committee on Outpatient (Office-Based) Surgery. Journal Medical Licensure and Discipline. 2002; 88:160-174).

- Core Principle #7: Physicians performing office-based surgery using moderate sedation/analgesia, deep sedation/analgesia or general anesthesia must obtain and maintain board certification by one of the boards recognized by the American Board of Medical Specialties, American Osteopathic Association, or a board with equivalent standards approved by the state medical board within five years of completing an approved residency training program. The procedure must be one that is generally recognized by that certifying board as falling within the scope of training and practice of the physician providing the care.

- Core Principle #8: Physicians performing office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia may show competency by maintaining core privileges at an accredited or licensed hospital or ambulatory surgical center, for the procedures they perform in the office setting. Alternatively, the governing body of the office facility is responsible for a peer review process for privileging physicians based on nationally recognized credentialing standards.

- Core Principle #9: For office-based surgery with moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia, at least one physician who is credentialed or currently recognized as having successfully completed a course in advanced resuscitative techniques (e.g., ATLS, ACLS, or PALS), must be present or immediately available with age- and size-appropriate resuscitative equipment until the patient has met the criteria for discharge from the facility. In addition, other medical personnel with direct patient contact should at a minimum be trained in Basic Life Support (BLS).

- Core Principle #10: Physicians administering or supervising moderate sedation/analgesia, deep sedation/analgesia, or general anesthesia should have appropriate education and training.

RESOLUTION

Subject: Rights of Minors to Consent for Pre-Exposure Prophylaxis for HIV

Submitted by: Connor Smith, Rachel Safeek, MPH, Jerome Soldo, Taylor Hood (University of Louisville School of Medicine)

Referred to: Reference Committee

WHEREAS, under Kentucky law (KRS 214.185), physicians may diagnose, prescribe for, and treat sexually transmitted diseases (STDs) for minors without obligation to obtain consent from or notify guardians at any point in the treatment continuum[1,2]; and

WHEREAS, KRS 214.185 does not explicitly allow minors to consent for STD preventive care, rendering a physician's ability to provide that care uncertain under current Kentucky law[1,2]; and

WHEREAS, the need to involve guardians in an adolescent's sexual or reproductive healthcare may deter adolescents from seeking care due to embarrassment, stigma, and fear of retribution[3,4,5]; and

WHEREAS, HIV prevalence among Kentucky residents aged 13+ in 2016 was 184 cases per 100,000, with a prevalence in Jefferson and Fayette Counties of 431 and 331 cases per 100,000, respectively[6]; and

WHEREAS, 4% of new HIV cases in Kentucky are diagnosed in adolescents aged 13-19[7]; and

WHEREAS, Truvada® (emtricitabine 200 mg/tenofovir 300 mg disoproxil fumarate) is FDA-approved as pre-exposure prophylaxis (PrEP) for HIV prevention in seronegative persons at increased risk of HIV infection, including adolescents who weigh at least 35 kg (77 lb)[8]; and

WHEREAS, daily PrEP use reduces the risk of sexual transmission of HIV by about 99%; among people who inject drugs, daily PrEP use reduces the risk of acquiring HIV by at least 74%[9,10]; and

WHEREAS, in 2019, the United States Preventive Services Task Force (USPSTF) established "A" rating recommendations that clinicians offer PrEP to persons who are at high risk of HIV infection[11]; and

WHEREAS, current Kentucky Medical Association policy supports removing barriers to prescribing PrEP and encourages physicians to prescribe PrEP when clinically indicated (Res. 2018-3); and

WHEREAS, current American Medical Association policy (H-60.958) urges state and local medical societies to support appropriate legislation to decrease the spread of STDs,

including HIV, by allowing minors to consent to prevention, diagnosis, and treatment of STDs; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support legislation to prevent minors from acquiring HIV, specifically by permitting minors to consent for Pre-Exposure Prophylaxis under the supervision of a qualified medical professional.

References


[1] Kentucky State Assembly. KRS § 214.185: Diagnosis and treatment of disease, addictions, or other conditions of minor. https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=48986

[2] Centers for Disease Control and Prevention. Minors' Consent Laws | Law | Policy and Law | HIV/AIDS | CDC. https://www.cdc.gov/hiv/policies/law/states/minors.html. Published 2018. Accessed August 19, 2019.

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[6] AIDSVu (aidsvu.org). Emory University, Rollins School of Public Health. https://aidsvu.org/state/kentucky/. Published 2019. Accessed August 19, 2019.

[7] Kentucky Cabinet For Health and Family Services (2018). HIV/AIDS Surveillance Report June 2018. https://chfs.ky.gov/agencies/dph/dehp/hab/Documents/AnnualReport2018.pdf

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[9] Centers for Disease Control and Prevention. Pre-Exposure Prophylaxis (PrEP) | HIV Risk and Prevention | HIV/AIDS | CDC. https://www.cdc.gov/hiv/risk/prep/index.html. Published 2019. Accessed August 19, 2019.

[10] Fonner VA, Dalglish SL, Kennedy CE, et al. Effectiveness and safety of oral HIV preexposure prophylaxis for all populations. AIDS. 2016;30(12):1973–1983. doi:10.1097/QAD.0000000000001145

[11] Owens D, Davidson K, Krist A et al. Preexposure Prophylaxis for the Prevention of HIV Infection. JAMA. 2019;321(22):2203. doi:10.1001/jama.2019.6390

**Relevant KMA and AMA Policy:**

KMA Resolution 2018-3 -- Pre-exposure Prophylaxis to Prevent HIV Transmission

1. KMA supports educating physicians and the public about the effective use of Pre-exposure Prophylaxis (PrEP) for human immunodeficiency virus prevention and encourages physicians to consider prescribing PrEP when clinically indicated.
2. KMA supports removing barriers to prescribing Pre-exposure Prophylaxis (PrEP) and advocating that individuals not be denied any insurance coverage on the basis of PrEP use.

AMA Policy H-60.958 -- Rights of Minors to Consent for STD/HIV Prevention, Diagnosis and Treatment

1. The AMA urges state and local medical societies to work with their respective health departments and communities to develop and support appropriate legislation to decrease the spread of sexually transmitted diseases (STDs) in minors, specifically by allowing minors to consent for the means of prevention, diagnosis and treatment of STDs, including AIDS.

RESOLUTION

Subject: Health Care Decision-Making for the Unbefriended. Two Physicians Rule for withdrawal of non-beneficial treatment of the Incapacitated and Alone

Submitted by: Aneeta Bhatia, MD

Referred to: Reference Committee

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WHEREAS, Clinicians increasingly confront un-represented patients who are incapacitated and have no “next of kin” or available surrogate to make their decisions or represent their treatment preferences; and

WHEREAS, Clinicians and researchers have described these patients as “unimaginably helpless,” “highly vulnerable,” because “no one cares deeply if they live or die,” unfortunately most often these patients continue to receive futile non beneficial care that may increase pain and suffering; and

WHEREAS, the estimated prevalence of decisional incapacity approaches 40% among adult medical inpatients and residential hospice patients and exceeds 90% among adults in some intensive care units[2]; and

WHEREAS, the growing therapeutic capabilities of medical science have become more effective in offering overzealous treatment to sustain failing vital functions, they may not always be promoting health.” Pope Francis; and

WHEREAS, despite articles drawing attention to this situation in law journals, medical journals, and bioethics journals, only a few States have adopted the two physician rule for withdrawing futile care in an unbefriended patient; now, therefore, be it

RESOLVED, that the Kentucky Medical Association requests Kentucky state legislative authority to authorize two attending physicians or a hospital ethics committee to withdraw non beneficial treatment when it has been determined that there is no discernable medical benefit, and that any intervention only postpones the imminent moment of death without serving the integral good; and be it further

RESOLVED, that a process be in place that provides the important safeguards of expertise, neutrality, and careful deliberation.

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