RESOLUTION 101

SUBJECT: Sunset Directives

INTRODUCED BY: Board of Governors

WHEREAS, it is the policy of the LSMS to sunset directives after two years, or upon completion, and

WHEREAS, the directives from 2020 were not sunset in 2022 due to the COVID-19 pandemic, therefore be it

RESOLVED, that the following LSMS directives originally approved in 2020 and 2021 be sunset per LSMS policy.

R107-20: Changes to the LSMS House of Delegates Annual Meeting
Directs the LSMS President to appoint an ad-hoc committee to study the feasibility of scheduling the Annual Meeting of the House of Delegates at a different time of the year. The committee shall be comprised of ten LSMS members including one representative from the Board of Governors, one representative from the Past Presidents Advisory Council, two representatives from the Young Physician Section, two representatives from the Resident and Fellow Section, one representative from the medical student section, the Chairman of the Council on Legislation, and the Speaker and Vice Speaker of the House of Delegates. The committee shall provide a report to the Board of Governors at each of its scheduled meetings in 2020, and provide a report, with recommendations, to the full House of Delegates during its 2021 Meeting in Baton Rouge. No changes should be made that impact existing contracts for future meetings of the House of Delegates. The directive could not be conducted in the manner stated in the resolution due to the COVID19 pandemic. However, in 2020, the LSMS Board of Governors held several meetings related to strategic planning related to the House of Delegates and the Speakers have implemented some of those recommendations such as the meeting continuing to occur in August, moving the presidential inauguration to lunch, and streamlining overall operations. However, the HOD still needs to be modernized and that process should continue and will via new directives offered as resolution R116-23 and R117-23.

R304-20: Tuberculosis testing among health care workers
Directs the LSMS urge the Louisiana Department of Health to require:

(1) Screen health care personnel and volunteers in hospitals, nursing homes and other medical/health care facilities, which are considered high risk for exposure to tuberculosis disease, at time of employment or time of beginning volunteering, with a test generally recognized by medical authorities as appropriate, e.g. the Purified Protein Derivative (PPD) skin test or the Interferon Gamma Release Assay (IGRA)

(2) Remove the requirement for annual re-screening of health care personnel and volunteers in the same medical/health care facilities in (1) above in the absence of known exposure to tuberculosis disease, and

(3) Provide education to all personnel and volunteers regarding tuberculosis on at least an annual basis. Before any action could be taken on this resolution the COVID19 pandemic occurred. Afterwards, there was no appetite by either the LSMS, LDH, hospitals, nursing homes, etc. to lessen any screening requirements post pandemic. This resolution could not be completed due to the politics, anti-vaccine, and overall anti-medicine movement that occurred throughout the state during and after the pandemic. No action was taken.

R402-20: Louisiana Direct Primary Care Pilot
Directs the LSMS work with the Louisiana Department of Health to initiate a Medicaid Direct Primary Care Practice pilot program. Multiple conversations were held with LDH, but no action was taken during and/or after the
pandemic. Currently, LDH does not have a secretary and a full-time replacement will not be appointed until 2024 after a new governor is elected.

**R403-20: Decreasing the demand for illicit drugs**
Directs the LSMS to seek and/or support advocacy campaigns at the local, state, and national level to educate the public on addiction and the hazards of recreational drug use, to include: policy or legislation that promotes research into effective methods of addiction treatment, mandates health insurance plans cover appropriate addiction treatment and supports investment in addiction research in the areas of cocaine and methamphetamine use. **At the state level, the LSMS did not file any legislation nor has there been any to support. However, at the federal level, the Medication Access and Training Expansion (MATE) Act passed in December 2022, requiring physicians complete a total of eight hours of training on the treatment and management of patients with opioid or other substance use disorders.**

**R121-21: AMA Strategic Plan to Embed Racial Justice and Advance Health Equity**
Directs the Louisiana Delegation to the AMA to submit a resolution asking the AMA to withdraw its Organizational Strategic Plan to Embed Racial Justice and Advance Health Equity (Equity Strategic Plan) and rewrite the recommendations for correcting its past support for racially discriminating behavior with removal of the inflammatory rhetoric. **A resolution was filed at the June 2022 AMA Annual meeting. An overwhelming amount of testimony against the resolution was provided in the reference committee, who ultimately recommended the resolution not be adopted by the House.**

**R201-21: APRN Independent Practice**
Directs the LSMS to work with other impacted physician organizations to strengthen collaborative practice agreements and establish a minimum acceptable criterion related to education, work experience, collaboration, and standard examinations required of any advanced practice registered nurse before agreeing to a limited scope of practice increase that would include licensure moving to the Louisiana State Board of Medical Examiners. **The majority of the statewide specialty medical societies and the LSMS remain vigilant in our opposition to scope of practice expansion. Multiple requests, both formal and informal, have been made to the LSBME to strengthen collaborative practice agreements.**

**R206-21: Supporting Patient Access to Medical Records**
Directs the LSMS to seek and/or support legislation or action that would improve access to medical records in a way that is fair to patients and physicians without risk of increased burden to the health care system. **No legislation has been filed related to this issue.**
RESOLUTION 102

SUBJECT: Reaffirming Policies

INTRODUCED BY: Steen Trawick, MD, Speaker
                    Reece Newsome, MD, Vice Speaker

WHEREAS, the LSMS automatically schedules its policies to sunset every five years, and

WHEREAS, in order to keep these policies, the House of Delegates must reaffirm them, therefore be it

RESOLVED, that the following LSMS policies be reaffirmed.

71.03 End of Life - End-of-Life Documentation

The documentation of End-of-Life information should be voluntary and used at the discretion of the physician.

Authority Note: R23-85; amended 1995; reaffirmed R101-03 and sub R101-08; reaffirmed as amended R102-13; reaffirmed R101-18

72.01 Physicians Gifts - Guidelines for Gifts to Physicians

The LSMS adopts the AMA CEJA opinion 8.061: To avoid the acceptance of inappropriate gifts, physicians should observe the following guidelines:

(1) Any gifts accepted by physicians individually should primarily entail a benefit to patients and should not be of substantial value. Accordingly, textbooks, modest meals, and other gifts are appropriate if they serve a genuine educational function. Cash payments should not be accepted. The use of drug samples for personal or family use is permissible as long as these practices do not interfere with patient access to drug samples. It would not be acceptable for non-retired physicians to request free pharmaceuticals for personal use or use by family members.

(2) Individual gifts of minimal value are permissible as long as the gifts are related to the physician’s work (eg, pens and notepads).

(3) The AMA Council on Ethical and Judicial Affairs defines a legitimate conference or meeting as any activity, held at an appropriate location, where (a) the gathering is primarily dedicated, in both time and effort, to promoting objective scientific and educational activities and discourse (one or more educational presentation(s) should be the highlight of the gathering), and (b) the main incentive for bringing attendees together is to further their knowledge on the topic(s) being presented. An appropriate disclosure of financial support or conflict of interest should be made.

(4) Subsidies to underwrite the costs of continuing medical education conferences or professional meetings can contribute to the improvement of patient care and therefore are permissible. Since the giving of a subsidy directly to a physician by a company’s representative may create a relationship that could influence the use of the company’s products, any subsidy should be accepted by the conference’s sponsor who in turn can use the money to reduce the conference’s registration fee. Payments to defray the costs...
of a conference should not be accepted directly from the company by the physicians attending the conference.

(5) Subsidies from industry should not be accepted directly or indirectly to pay for the costs of travel, lodging, or other personal expenses of physicians attending conferences or meetings, nor should subsidies be accepted to compensate for the physicians’ time. Subsidies for hospitality should not be accepted outside of modest meals or social events held as a part of a conference or meeting. It is appropriate for faculty at conferences or meetings to accept reasonable honoraria and to accept reimbursement for reasonable travel, lodging, and meal expenses. It is also appropriate for consultants who provide genuine services to receive reasonable compensation and to accept reimbursement for reasonable travel, lodging, and meal expenses. Token consulting or advisory arrangements cannot be used to justify the compensation of physicians for their time or their travel, lodging, and other out-of-pocket expenses.

(6) Scholarship or other special funds to permit medical students, residents, and fellows to attend carefully selected educational conferences may be permissible as long as the selection of students, residents, or fellows who will receive the funds is made by the academic or training institution. Carefully selected educational conferences are generally defined as the major educational, scientific or policy-making meetings of national, regional, or specialty medical associations.

(7) No gifts should be accepted if there are strings attached. For example, physicians should not accept gifts if they are given in relation to the physician’s prescribing practices. In addition, when companies underwrite medical conferences or lectures other than their own, responsibility for and control over the selection of content, faculty, educational methods, and materials should not belong to the organizers of the conferences or lectures.

Authority Note: R115-03, reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

90.03 Health Care Facilities - Code Situation in Health Care Facilities

The LSMS supports the inclusion of coverage in Louisiana’s Good Samaritan Laws of services rendered in a code situation in a health care facility by physicians who are not the attending or consulting physicians to the patient.

Authority Note: R210-93, reaffirmed R101-03, reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

91.01 Hospitals; Organized Medical Staff - Guidelines for Hospital Medical Staffs

The LSMS supports the following guidelines characterizing the relationship between hospitals and their medical staffs:

(1) Hospital privileges should be established according to the bylaws of the medical staff, which includes the concept of quality peer review

(2) Physicians should provide medical care based on the traditional patient-physician relationship.

(3) Renewal of hospital privileges should be based on demonstrated competence and ethical behavior.

(4) Physician members of hospital medical staffs shall have the due process rights of a fair hearing and appellate review regardless of any personal service contract whenever a hospital denies reappointment to the medical staff, terminates the privileges of a physician, or takes any adverse action against a physician.

Authority Note: R15-84; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

100.04 LSMS Access to Better Care Plan

The LSMS supports the principals of our Access to Better Care proposal for reforming Medicaid, which includes pluralistic options including but not limited to: defined contribution plans, Medicaid Advantage plans, vouchers, and Medicaid medical savings accounts.
100.09 Health Care Reform - Health System Reform

The LSMS supports a policy of pluralism in our health care delivery system and includes the principles of security, simplicity, savings, choice, quality, and responsibility for health system reform.

(1) The LSMS supports a pluralistic system of health care delivery wherein patients have multiple choices of health care financing mechanisms in an open market setting free of government approved advantages created to favor any one or more mechanisms.

(2) The LSMS supports freedom of choice of health and medical care delivery settings for patients and physicians.

(3) The LSMS supports the right of physicians to choose their own specialty of practice and opposes any quota system to force physicians into a particular specialty or mode of practice. (4) The LSMS urges the American Medical Association and the specialty societies to work together to preserve and expand the right of patients to choose their physician, delivery setting and method of financing of health care and the right of physicians to choose their practice setting and compensation arrangement.

(5) The LSMS supports the position of value and cost effectiveness instead of draconian cost containments, making our health care delivery system accountable to patients instead of to government, insurance companies, employers, hospitals or physicians.

The LSMS advocates the term health system reform to characterize needed changes to our health care delivery system.

Authority Note: R301/302-93; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed as amended R101-18

100.11 Health Care Reform - Cost Effective Health Care System

The LSMS supports the following principles for achieving a realistic functional approach to a market system method of achieving cost-effectiveness in health care:

a. Greater reliance on market forces, with patients empowered with understandable fee/price information and incentives to make prudent choices, and with the medical profession empowered to enforce ethical and clinical standards which continue to place patients' interests first, is clearly a more effective and preferable approach to cost containment than is a government-run, budget-driven, centrally controlled health care system.

b. Individuals should have freedom of choice of physician and/or system of health care delivery. Where the system of care places restrictions on patient choice, such restrictions must be clearly identified to the individual prior to their selection of that system.

c. In order to facilitate cost-conscious, informed market-based decision-making in health care, physicians, hospitals, pharmacies, durable medical equipment suppliers, and other health care providers should be required to make information readily available to consumers on fees/prices charged for frequently provided services, procedures, and products, prior to the provision of such services, procedures, and products. There should be a similar requirement that insurers make available in a standard format to enrollees and prospective enrollees' information on the amount of payment provided toward each type of service identified as a covered benefit.

d. Federal and/or state legislation should authorize medical societies to operate programs for the review of patient complaints about fees, services, etc. Such programs would be specifically authorized to arbitrate a fee or portion thereof as appropriate and to mediate voluntary agreements
and could include the input of the state medical society and the AMA Council on Ethical and Judicial Affairs.

e. Physicians are the patient advocates in the current health system reform debate. Efforts should continue to seek development of a plan that will effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

f. Efforts should continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront.

Authority Note: R406-97, reaffirmed R101-06, reaffirmed R101-11; reaffirmed R101-16; amended R107-17; reaffirmed R101-18

110.02 Health Information - Third Party Requests for Patient Information

Third party insurance administrators should be required to furnish the physician with a properly executed release of information as required by law prior to the physician’s release of any medical reports, x-rays or other information regarding the patient’s diagnosis and treatment.

Authority Note: R10-89; referred to BOG 1999; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

120.06 Health Insurance - Pre-Admission Certification

The LSMS opposes the concept of pre-admission certification.

Authority Note: R17-84; reaffirmed R101-03 and sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

120.08 Health Insurance - Any Willing Provider

The LSMS supports laws and/or regulations that would prohibit a health insurance issuer from refusing to allow a doctor of medicine or osteopathic medicine, who is located within the coverage area of the health insurance issuer and is willing to accept the contract terms and conditions of participation, to join the panel of the issuer as a participating provider.

Authority Note: R206-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

121.05 Eligibility, Benefits & Coverage - Cancellation of Group, Family or Blanket Health Insurance

The LSMS supports health insurance policy coverage which (1) prohibits cancellation of group, family, or blanket health insurance policies after claims for terminal, incapacitating, or debilitating conditions; (2) requires notified insurers to pay for certain claims for illnesses or conditions occurring prior to cancellation of any health policy; (3) prohibits an increase in rates unless the increase is actuarially justified and is based on community experience and the experience and projections for the appropriate pool; and (4) prohibits a premium increase based solely or primarily on the experience with the group which includes an insured with a terminal, incapacitating, or debilitating condition.

Authority Note: R69-91; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18
122.02 Health Care Quality Initiatives - Public Reporting of Health Quality Indicators

The LSMS supports public reporting of health quality measures including those by Department of Health and Human Services, Centers Medicare and Medicaid Services, Agency for Healthcare Research and Quality, Centers for Disease Control and Prevention, and National Quality Forum.

Authority Note: R303-03; reaffirmed sub R101-08; reaffirmed as amended R102-13; reaffirmed R101-18

130.03 Indigent and Uninsured - Reforming Care for the Uninsured

The LSMS work with the Louisiana Department of Health and Hospitals and the Louisiana Legislature to develop and implement a fiscally sound, quality plan to address the need for access to quality medical care for indigent and uninsured populations in the state.

Editorial Note: All see Health Care Reform (100)
Authority Note: R214-94; reaffirmed R101-04; reaffirmed R101-10; reaffirmed as amended R107-13; reaffirmed R101-18

140.02 LSMS: Administration and Organization - LSMS Annual Meeting

The Board of Governors establish the dates and location of the annual House of Delegates meeting upon the recommendation of the Speakers of the House of Delegates.

Authority Note: R125-03; reaffirmed sub R101-08; reaffirmed R101-13; reaffirmed R101-18

150.04 Medicaid - Medicare-Medicaid Crossover Payments

The Louisiana Department of Health and Hospitals alter its existing rules concerning reimbursement of physicians for care of dually eligible (Medicare/Medicaid) beneficiaries to allow for full cost-sharing of co-payments and deductibles, as mandated by federal Medicare and Medicaid laws. The LSMS, together with component societies, join with existing statewide patient advocacy coalitions, to encourage the Louisiana Department of Health & Hospitals to restore funding for Medicare-Medicaid crossover payments.

Editorial Note: Also see Medicare (190)
Authority Note: R408-01; reaffirmed R102-06; reaffirmed R101-11; reaffirmed R101-16; reaffirmed R103-21

160.01 Medical Education - Medical Education Policy

The LSMS believes the ultimate purpose of medical education—including basic medical education for medical students and provisionally registered doctors, postgraduate training and continuing medical education (CME)—is to train the very best physicians, which in turn can improve the health and the health care of the population and ensure the vibrant and robust future of the practice of medicine. The LSMS
The LSMS endorses all efforts and initiatives which further the pursuit of medical education. These efforts include but are not limited to the following:

1. Ensuring appropriate funding exists and is dedicated to supporting the medical schools located in Louisiana.
2. Making available sufficient and appropriate financial aid, whether through grant or loan programs, which encourages Louisiana citizens to enter into medical school and begin their journey into the practice of medicine.
3. Ensuring that residency programs in the state are well supported both from a financial standpoint and an educational standpoint ensuring that Louisiana physicians are educated not only to handle the challenges of real-life medical practice but also to prepare for an ever-changing health care system.
4. Encouraging physicians in Louisiana to continue their medical education and to earn, on a voluntary basis, the AMA’s Physician Recognition Award or comparable awards given my medical specialty organizations.
5. Ensuring the appropriate governance and leadership autonomy for the public medical schools in Louisiana by continuing the current governance practice of direct reporting of the chancellors at LSUHSC-New Orleans and LSUHSC-Shreveport to the LSU System President.
6. Ensuring public-private partnerships created with teaching hospitals connected with GME Programs in Louisiana medical schools are structured in a way that supports adequate financial and academic resources with the goal of preserving and improving the GME system in Louisiana.

**Authority Note:** R108-13; reaffirmed R101-18

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**190.01 Medicare - Louisiana as One Medicare Region**

The LSMS endorses designation of the entire state one region for the purpose of reimbursement under Part B of Medicare.

**Authority Note:** R22-83; reaffirmed 1988; reaffirmed 1998; reaffirmed R101-03; referred to the Board of Governors sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

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**190.03 Medicare - Medicare Payments to New Physicians**

The LSMS opposes discriminatory Medicare payment reductions to new physicians.

**Authority Note:** R55-92, reaffirmed R101-03, reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

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**200.02 Mental Health - Discrimination against Psychiatric Consultation**

The LSMS opposes the policy of insurers that treat consultation for patients with psychiatric symptoms in a discriminatory manner. Primary insurers be held fully accountable for the policies and performance of their subcontractors and be held fully responsible for the equitable treatment of all patients and provide timely reimbursement for legitimate services under their plans, whether subcontracted or not. Further, primary insurers be required to cancel contracts with subcontractors no longer financially able to provide contracted services without resorting to discriminatory practices.

**Authority Note:** R216-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

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**210.01 Physicians - Definition of a Physician**
A physician is a person who has been admitted to a medical school or a school of osteopathic medicine, which school is approved by his or her state licensing board, and has successfully completed the prescribed course of studies, has graduated and holds a diploma as a doctor of medicine or osteopathic medicine and has completed the requisite qualifications to be licensed to practice medicine or osteopathic medicine. The LSMS supports limiting the use of the term physician to describe only doctors of medicine or osteopathic medicine.

Authority Note: R16-84; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

212.01 Licensure and Discipline - Separate Physician Licensing Boards

The LSMS opposes the creation of separate physician licensing boards apart from the Louisiana State Board of Medical Examiners.

Authority Note: R508-93; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

212.12 Licensure and Discipline - Licensure Should not be Tied to EHR Proficiency

The LSMS opposes the denial of a medical license to any physician based solely on the grounds of failure to use an electronic health record (EHR), or failure to demonstrate proficiency in use of an electronic health record.

Authority Note: R106-18

213.02 Physician Contracts & Payment - Right of Physician and Patient to Privately Contract

The LSMS holds inviolate the constitutional right of citizens to enter into private contracts, such as between physician and patient, and the right of the parties to determine the arrangements under which services are rendered. The LSMS unalterably opposes any legislation that (1) interferes with the right of private contract between citizens; (2) prohibits a physician from directly billing a private patient; (3) mandates physician acceptance of patient coverage benefits.

Authority Note: R20-84; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

213.11 Physician Contracts & Payment - Reducing Payment for Previously-Adjudicated Claims

The LSMS supports policies which prohibit third-party payors, including government plans, from reducing or withholding payment on current or future claims to satisfy corrections or alterations to unrelated previously-adjudicated claims. The LSMS supports policies which instead require third-party payors to notify physicians of the need to remit a separate payment for the error which resulted in overpayment.

Editorial Note: Also See Health Insurance (120), Medicare (190) & Medicaid (150)

Authority Note: R210-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18
213.13 Physician Contracts & Payment - Health Plan Charges for Tracing Third-Party Checks

The LSMS opposes any business practice by an insurance company, employer-sponsored plans, or third-party administrators which requires payment of a fee to trace a check which, according to them, has been sent to the physician previously. The LSMS supports policies which require health insurance plans and/or employer-sponsored plans and/or third-party administrators to issue a replacement check or submit for signature by the physician, an acknowledgment of non-receipt of the check and/or request for reissue after 60 days if the original check has not been processed by the physician.

Authority Note: R211-03; reaffirmed sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

213.15 Physician Contracts & Payment - Contracts and Ethical Duty

The LSMS opposes agreements or clauses in participating physician contracts which unreasonably restrain the physician from providing information to the patient about policies and decisions of an insurer or other contracting entity. These provisions constitute an unacceptable restriction on the physician's ethical duty to act as the patient's advocate.

Authority Note: R511-93; reaffirmed R101-03; and sub R101-08; reaffirmed R102-13; reaffirmed R101-18

213.21 Physician Contracts & Payment - National Health Insurance and Physician Payment

The LSMS opposes any provision in any national health insurance legislation which would preclude billing of patients by physicians and encourages the AMA to take the same position.

Authority Note: R705-74; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

213.22 Physician Contracts & Payment - Equitable and Adequate Reimbursement

The LSMS supports equitable and adequate reimbursement to physicians in order to increase access to care.

Authority Note: R105-18

214.01 Physician Patient Relationship – General Policy

The LSMS principles of the physician/patient relationship:
(1) Patients should seek a clear understanding of fees with their physician. Neither the patient nor the physician should be hesitant to talk about this important financial consideration.
(2) The patient should make every effort to pay the physician’s bill promptly. Because most physicians do not charge interest on unpaid balances, delay in settling a bill translates into an increase in the cost of medical practice which, like all other costs, is passed on to future patients.
(3) The physician should be told if a patient is in a hardship situation. A physician’s first obligation is to provide good medical care. One of the most disturbing things about government intrusion is the failure
to acknowledge that physicians in this country are traditionally willing to adjust to the needs of their patients on a case by case basis when genuine hardship occurs.

(4) Patients should be able to rely on their physicians as their advocate. Physicians should explain to patients all known costs of medical care (hospitals, tests, therapy, etc.).

(5) Patients should establish a relationship with a primary care physician for their confidential health maintenance and emergency needs.

(6) Physicians should accommodate second opinions for those patients who are uncomfortable with a diagnosis or treatment plan.

(7) Patients should do everything possible to promote and maintain their well-being such as: fastening seat belts and child restraints, abstaining from smoking, maintaining good nutrition, exercise and practicing temperance in alcohol consumption.

Authority Note: R10-85; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

215.01 Physician Referral – Incentives

The LSMS opposes business practices whereby payments by or to a physician are made solely for the referral of a patient. A physician should not accept payments for prescribing or referring a patient to said source. Referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

Authority Note: R8-85; reaffirmed R101-95; reaffirmed R101-03 and sub R101-08; reaffirmed as amended R103-B-13; reaffirmed R101-18

215.02 Physician Referral - Self-Referral

The LSMS believes that in general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(1) Ensure that referrals are based on objective, medically relevant criteria.

(2) Ensure that the arrangement:
   (a) is structured to enhance access to appropriate, high quality health care services or products; and
   (b) within the constraints of applicable law:
      (i) Does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
      (ii) Does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services, and
      (iii) Adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.

(3) Take steps to mitigate conflicts of interest, including:
   (a) ensuring that financial benefit is not dependent on the physician-owner/investor’s volume of referrals for services or sales of products;
   (b) establishing mechanisms for utilization review to monitor referral practices; and
   (c) identifying or if possible, making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.

(4) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.
233.03 Medical Malpractice - Limitations on Malpractice Recovery

The LSMS is committed to preserving a total cap on medical professional liability damage awards paid by or on behalf of health care providers in Louisiana and supports other changes in the medical professional liability statutes that enhance affordability and availability of medical professional liability insurance.

Authority Note: R203-01; amended R102-06; amended R207-08; reaffirmed R201-13; reaffirmed R101-18

233.05 Medical Malpractice - Opposition to Safe Harbor Defense in Medical Professional Liability

The LSMS is opposed to the use of safe harbor defenses, wherein guidelines are purported to be accepted as the standard of care, in matters pertaining to medical professional liability.

Authority Note: R112-13; reaffirmed R101-18

233.08 Medical Malpractice - Penalties for Frivolous Malpractice Suits

The LSMS supports the imposition of penalties applied to an individual plaintiff or an attorney and his or her client who files a medical malpractice action without merit against a physician licensed to practice medicine in Louisiana.

Authority Note: R34-86; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

233.09 Medical Malpractice - Contingency Fee System

The LSMS supports revision of the contingency fee system in medical professional liability suits so that a graduated scale of attorney fees, consistent with reforms passed in other states, be applied to any liability settlements or awards.

Authority Note: R31-86; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R103-A-13; reaffirmed R101-18

241.05 Children and Youth - Standards for Child Care Institutions

The LSMS supports a mandate for child care standards in all child care institutions and the immediate closure of those institutions found to be in violation of these standards.

Authority Note: R54-84; reaffirmed R101-03; and sub R101-08; reaffirmed R102-13; reaffirmed R101-18

241.07 Children and Youth - Standardization of Child Health Certificate

The LSMS supports the development of a standardized Child Health Certificate for children attending day care centers, elementary, middle or high schools and a process for updating the Certificate. All day
care centers, elementary, middle or high schools be required to use the most recent standardized Child Health Certificate, and all previous versions be abandoned.

Authority Note: R207-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

280.03 Tobacco - No Smoking in Public Places

The LSMS opposes smoking in public places or public meetings except in designated smoking areas. Smoking areas should not be designated in places prohibited by the fire marshal or by other law, ordinance or regulation and smoking be restricted in all Louisiana hospital and state office buildings, including the state Capitol.

Authority Note: R64-89; reaffirmed 1999 and R25-1984; reaffirmed R101-03; reaffirmed sub R101-08; reaffirmed R102-13; reaffirmed R101-18

290.01 Women’s Health - Elective Deliveries Prior to 39 Weeks

The LSMS supports the policy of ending elective non-medically indicated inductions and elective non-medically indicated C-sections prior to 39 weeks in physician practice and community settings.

Authority Note: R301-11; reaffirmed as amended R201-13; reaffirmed R101-18
RESOLUTION 103

SUBJECT:  LDH collaboration

INTRODUCED BY:  Debbie Fletcher, MD

WHEREAS, LDH has excellent programs for loan repayment and rural health programs

RESOLVED, LSMS collaborate with LDH to publicize these programs
RESOLUTION 104

SUBJECT: Artificial Intelligence in Medicine

INTRODUCED BY: Richard Paddock, MD, President-Elect

WHEREAS, the recent rise in artificial intelligence (AI), particularly in medicine brings a lot of unknown, and

WHEREAS, the practice of medicine is an art that can never be replaced by AI, and

WHEREAS, some institutions and/or payors may want to replace physicians with AI, and

WHEREAS, the patient and physician relationship remains vital to providing quality health care, and

WHEREAS, patients trust their physician and not a computer, therefore be it

RESOLVED, that artificial intelligence (AI) programs and AI-derived algorithms should not be or become the sole determinants of clinical decision-making; and be it further

RESOLVED, that healthcare entities should not receive reimbursement for medical decision-making performed by AI programs and AI-derived algorithms alone; and be it further

RESOLVED, that a physician should be required to endorse/sign-off/approve any reimbursable action taken by an AI program or AI-derived algorithm; and be it further

RESOLVED, that the LSMS seek and/or support legislation that prevents artificial intelligence (AI) programs and AI-derived algorithms from becoming the sole determinants of clinical decision-making; and prevents healthcare entities from being reimbursed for medical decision-making performed by AI programs and AI-derived algorithms alone; thus, requiring a physician to endorse/sign-off/approve of any reimbursable action taken by an AI program or AI-derived algorithm.

Speakers Note: the first three resolve statements will create a new LSMS policy. Resolve statement #4 creates a directive for action.
RESOLUTION 105

Subject: Regulation of Artificial Intelligence and Increase in Evidence Based Research to Guide Related Emerging Technologies in Clinical Practice

Introduced by: Medical Student Section

WHEREAS, the use of Artificial Intelligence (AI) and subsequent Machine Learning (ML) technology has been employed to diagnose, treat, prescribe medications, and predict patient outcomes $^{1,2}$; and,

WHEREAS, The American Medical Association (AMA) has policy (H-480.939) for the use of AI in healthcare settings so long as it facilitates the goals of increasing public health standards, further the patient-physician relationship, and in no ways serves as a replacement$^3$; and improving patient outcomes$^3$; and,

WHEREAS, insurer entities such as the Centers for Medicare and Medicaid Services (CMS),, has approved appropriate payment reimbursement plans for costs associated with the use of AI technologies in healthcare settings$^4$; and,

WHEREAS, medical professionals and medical students have supported the use of AI and related technologies with standardization of practices and protocols for their integration in the healthcare and health education settings$^5$; and

WHEREAS, helpful in their respective utilizations emerging AI technologies, have been associated with pitfalls related to programing and proofreading, additionally, medical applications in the use of AI for diagnostic purposes have made recurring mistakes in settings of inappropriate clinical use $^6,7$; and

WHEREAS, in hopes to mitigate mistakes made by AI technologies in healthcare settings a supervisory model, mandating physician oversight, has been identified as the best application of related technologies by clinical researchers and physicians studying medical AI applications, and further advocate for standardization of reporting protocols for AI technologies for improved clinical accuracy $^1,8$; therefore be it,

RESOLVED, that our LSMS support physician oversight regarding the clinical uses of artificial intelligence and related technologies; and be it further

RESOLVED, that our LSMS develop clinical use guidelines for artificial intelligence and related technologies; and be it further
RESOLVED, that our LSMS advocate for an increase in availability for educational programs and resources that strengthen familiarity with clinically relevant artificial intelligence applications and related technologies in state medical education institutions.

References:
3. AMA. Augmented Intelligence in Health Care H-480.939.
RESOLUTION 106

SUBJECT: Updating the Medical Affiliate Membership Category

INTRODUCED BY: Board of Governors

WHEREAS, the Louisiana State Medical Society and its partners, began working on an association sponsored health plan in 2021, and

WHEREAS, the Louisiana State Medical Society House of Delegates created a membership category for medical/dental affiliate members who are not eligible for any other LSMS membership category but are a member of a health-related organization licensed by the Louisiana State Board of Medical Examiners or a dentist licensed by the Louisiana State Board of Dentistry, and

WHEREAS, the Louisiana State Medical Society officially launched its association-sponsored self-funded health plan known as Advantage Physicians Healthcare Trust (APHT) on February 1, 2023, and

WHEREAS, other individuals and groups working in allied health professions have expressed interest in participating in the plan but do not meet the current definition of medical/dental affiliate, therefore, be it

RESOLVED, that the Medical/Dental Affiliates membership category be expanded to include other allied health professionals licensed by the Louisiana Physical Therapy Board (LPTB), the Louisiana State Board of Examiners of Psychologists (LSBEP) and employees of vendors that primarily serve the Louisiana medical community, and be it further

RESOLVED, that to facilitate this change, Article IV of the LSMS Bylaws be amended to add the following:

Article IV

Section 10 – Medical/Dental Affiliates

A. Qualifications
   A medical/dental affiliate member
   1. A person not eligible for any other LSMS membership section, however, is a member of a health-related organization. Affiliate membership may be granted upon subscription to certain Society products and/or services.
2. Must be licensed by the licensed by the Louisiana Board of Medical Examiners or any dentist licensed by the Louisiana State Board of Dentistry or licensed by the Louisiana Physical Therapy Board or licensed by the Louisiana State Board of Psychologists or employed on a full-time basis by a vendor that primarily serves the Louisiana Medical Community.

3. Need not be licensed to practice medicine in Louisiana.
RESOLUTION 107

SUBJECT: Amendment of LSMS Policy 213.16

INTRODUCED BY: F. Jeff White, MD

WHEREAS, data from the American Medical Association (AMA) indicate that in 2020 50.2% of all patient care physicians were employees, and

WHEREAS, an April 2022 study from the Physicians Advocacy institute found a sharp uptick in physician employment during the course of the COVID-19 pandemic, with 73.9% of U.S. physicians employed by hospitals or corporate entities by the end of 2021, and

WHEREAS, the AMA supports the right of physicians to engage in collective bargaining, and it is AMA policy to work for expansion of the numbers of physicians eligible for that right under federal law (Policy H-385.946; Policy H-385.976), therefore be it

RESOLVED,

That Policy 213.16 of the Louisiana State Medical Society be amended as follows:

213.16 Physician Contracts & Payment - Physician Negotiating Units The LSMS supports the right for all physicians to form local and/or regional negotiating units consistent with our medical ethics and professionalism for the purpose of collectively bargaining with managed care plans, insurers, and employers on issues related to health care quality, patient rights, and physician rights, and does not oppose the affiliation of physician negotiating units with labor unions and of the negotiating units without nor the right to strike, consistent with applicable law.
RESOLUTION 108

SUBJECT: Policy Statement on the Corporate Practice of Medicine

INTRODUCED BY: Jamie Kuo, MD

WHEREAS, A significant number of the nation’s hospitals, emergency departments, same-day surgery centers including anesthesiologists, psychiatric inpatient facilities, outpatient clinics, etcetera, are increasingly controlled by staffing companies with private equity backing or ownership

WHEREAS, private equity ownership in healthcare is associated with increased healthcare costs and decreased quality of care.

WHEREAS, private equity should be restricted from influence the practice of medicine

WHEREAS, The Corporate Practice of Medicine (CPOM) doctrine exists in many states as a legal doctrine to keep the business interest out of the physician-patient relationship; and

WHEREAS, The CPOM doctrine has as its main purpose the protection of patients and the avoidance of the commercialization of the practice of medicine; and

RESOLVED, That LSMS adopt the following policy statement on the Corporate Practice of Medicine based on the California Medical Board

*LSMS Policy Statement on the Corporate Practice of Medicine*

LSMS strongly believes that the physician-patient relationship should be free of commercialization and undue influence by business interests. The corporate practice of medicine prohibition is intended to prevent unlicensed persons from interfering with or influencing the physician’s professional judgment. The decisions described below are examples of some of the types of behaviors and subtle controls that the corporate practice doctrine is intended to prevent. The following health care decisions should be made by a licensed physician and would constitute the unlicensed practice of medicine if performed by an unlicensed person:

- Determining what diagnostic tests are appropriate for a particular condition.
- Determining the need for referrals to, or consultation with, another physician/specialist.
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient.
• Determining how many patients a physician must see in a given period of time or how many hours a physician must work.
In addition, the following “business” or “management” decisions and activities, resulting in control over the physician’s practice of medicine, should be made by a licensed physician and not by an unlicensed person or entity:
• Ownership is an indicator of control of a patient’s medical records, including determining the contents thereof, and should be retained by a licensed physician.
• Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants.
• Setting the parameters under which the physician will enter into contractual relationships with third-party payers.
• Decisions regarding coding and billing procedures for patient care services.
• Approving the selection of medical equipment and medical supplies for the medical practice.
The types of decisions and activities described above cannot be delegated to an unlicensed person, including (for example) management service organizations. While a physician may consult with unlicensed persons in making the “business” or “management” decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.
The following types of medical practice ownership and operating structures also are prohibited:
• Non-physicians owning or operating a business that offers patient evaluation, diagnosis, care, or treatment.
• Management service organizations arranging for or providing medical services rather than only providing administrative staff and services for a physician’s medical practice (non-physician exercising controls over a physician’s medical practice, even where physicians own and operate the business).
RESOLUTION 109

SUBJECT: Eliminating Use of the Word “Provider” in All LSMS Communications

INTRODUCED BY: Jamie Kuo, MD

WHEREAS, The word/term “provider” has become commonplace in referring to medical professionals; and

WHEREAS, This term is generic, and provides no descriptor for patients or staff, giving them no clues as to the level of expertise or training attained by a given medical professional; and

WHEREAS, This generic term is ubiquitous and often refers to routine services such as internet provider, insurance provider, food service provider, sanitation provider, etc.; and

WHEREAS, No other professions such as attorneys, engineers, architects, dentists, or accountants, et al., refer to people with differing levels of training or expertise by a single non-specific generic term; and

WHEREAS, This generic term denigrates and devalues all medical professions and the people who have attained professional status in medicine; and

WHEREAS, It is not difficult to refer to medical professionals by the titles they have earned; and

WHEREAS, Referring to medical professionals by the generic term “provider” also devalues their role in patient care; therefore be it

RESOLVED, That LSMS, in its official publications, discussions, announcements, communications, and documents, etc., will work to eliminate the use of the word “provider” when referring to physician and non-physician healthcare practitioners, instead referring to them more accurately by the educational degree(s) and titles that they obtained.
RESOLUTION 110

SUBJECT: Adopt and publish a position statement on the use of the term “provider”

INTRODUCED BY: Jamie Kuo, MD

WHEREAS, according to CMS definitions, “provider” has multiple definitions:

• “Any Medicare provider (e.g., hospital, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, end-stage renal disease facility, hospice, physician, non-physician provider, laboratory, supplier, etc.) providing medical services covered under Medicare Part B.”

• Any organization, institution, or individual that provides health care services to Medicare beneficiaries. Physicians’ ambulatory surgical centers, and outpatient clinics are some of the providers of services covered under Medicare Part B.

• A doctor, hospital, health care professional, or health care facility

WHEREAS, the use of the term “provider” in health care originated in government and insurance sectors to designate health care delivery organizations

WHEREAS, the use of the term “provider” has expanded to include a growing set of health care professionals who qualify for payment by federal monies

WHEREAS, the term “provider” has evolved to suggest healthcare as a commodity with the Physician as the provider of commoditized medical service and the patient as the “customer”

WHEREAS, Physicians practice medicine and do not sell commoditized healthcare services.

WHEREAS, the use of the term “provider” is offensive to dedicated Physicians and is devoid of any reference to their training and earned degrees and titles and to their learned profession of medicine

WHEREAS, the following societies have published a position statements or resolutions on the use of the term “provider”:

• The American Academy of Family Physicians

• The American Academy of Emergency Physicians

• The American Psychiatric Association

• The American College of Physicians
WHEREAS, physicians, nurse practitioners, physician assistants and all other individual “providers” as defined by CMS, should be referred to as their professional titles and not the generic term “provider” and be it

RESOLVED, the LSMS will adopt a position statement on the use of the term provider including guidelines and suggestions for term usage.

RESOLVED, the adopted position statement will be published under “LSMS Position Statements” on the official public-facing website and in the next issue of the Journal of the LSMS.
RESOLUTION 111

Subject: Mentor-Mentee Programs for First-Year Medical Students

Introduced by: Medical Student Section

WHEREAS, Louisiana is poorly ranked for both healthcare and education out of all 50 states, according to a recent national report, demanding that immediate action be taken to address both of these issues; and

WHEREAS, peer mentorships have been found to be a good addition when offered alongside faculty mentoring; and

WHEREAS, in a systematic review it was found that a variety of mentorship styles were successful on the basis of satisfaction; and

WHEREAS, peer mentorships for medical residents have been found to aid in developing communication skills, encouraging academic and scholarly success, supporting career development, helping develop a sense of community, and improving coping skills and psychosocial wellbeing; and

WHEREAS, peer mentoring programs provide a “range of benefits including improving students exam scores, acquisition of procedural skills, and in improving the communication skills and personal and professional development of both mentors and mentees”; and

WHEREAS, the presence of mentors was found to be a prominent influence on student specialty choice; and

WHEREAS, in a cross-sectional study analyzing mentor-mentee relationships where 61 survey respondents were evaluated, it was found that 59% of participants expressed dissatisfaction with the mentorship they received during medical school, while 63.9% rated their mentorship experience as good or very good, revealing three key themes: positive mentorship experiences among students pursuing primary care, inadequate mentorship reported by female students, and a need for improvement in formal mentorship programs; and

WHEREAS, a prospective, quasi-experimental study on mentorships and student burnout found that 81.3% the medical students who participated in a mentorship program during their 4th year rotations at 2 separate institutions experienced decreased stress levels and 82.6% of participants strongly agreed that their mentors provided beneficial emotional support; and
WHEREAS, the Step Siblings Program provided by the University of Vermont LCOM was shown to be helpful to the students in the process of preparing for step 1 with mental health and wellness and was implemented as a permanent addition to the school after its initial pilot year; and

WHEREAS, summer research positions are offered at many universities nationwide to first-year medical students which promote experiential learning and professionalism; and

WHEREAS, at Tulane, the vision of the Tulane Learning Communities of the Tulane University’s School of Medicine is that “[they] aim to enhance the social connectivity of the School of Medicine and provide direct mentoring to students through individual meetings and group social events”; and

WHEREAS, the presence of mentorships may help to address goals of medical schools such as Oschner in terms of health inequity via “education which includes workforce development to create a diverse and inclusive pipeline of healthcare providers and training so that all healthcare providers understand the importance of diversity, inclusion and health equity”; and

WHEREAS, valuable insight into surgery, its subspecialties, and the lived experiences of female surgeons from a variety of different specialties was obtained from prior experience as a mentee in the Association of Women Surgeons; and

WHEREAS, the most recent and extensive meta-analysis to date regarding group mentorship for medical students recommended that mentorship programs be longitudinal and mandatory for all students for optimal organization and utilization, as group mentoring exhibited the following positive effects for the mentees: increased personal and social support, improved student satisfaction, and professional growth; and

WHEREAS, AMA policies H-200.951 and H-65.961, support and acknowledge mentorship and sponsorship as integral components of career advancement; therefore be it,

RESOLVED, the LSMS collaborates with Louisiana medical schools to create a mentorship program to enhance the training of Louisiana medical students.

Fiscal Note:

References:


Relevant LSMS Policy
160.06 Medical Education – Graduate Medical Education
The LSMS supports the creation of additional graduate medical education positions within the state. Authority Note: R201-22

245.04 Public Health Education – Suicide Assessment, Intervention and Management
The LSMS advocate for the advancement of statewide programs targeted at providing resources that improve public literacy on suicide and prevention. To include:
1. Training in mental health literacy, including (1) recognition of suicide warning signs in patients, (2) preventative steps that can be taken, and (3) proper intervention during an active suicide attempt. 2. A comprehensive suicide prevention program.
3. Peer support programs for youth and the creation of school programs which mitigate suicide risk in adolescents. 4. Support for effective clinical, professional, and community practices which will reduce mental health stigma and aid in identifying individuals at risk for suicide. Authority Note: R303-19

AMA Policy
Principles for Advancing Gender Equity in Medicine H-65.961
Our AMA:
1. declares it is opposed to any exploitation and discrimination in the workplace based on personal characteristics (i.e., gender);
2. affirms the concept of equal rights for all physicians and that the concept of equality of rights under the law shall not be denied or abridged by the U.S. Government or by any state on account of gender;
3. endorses the principle of equal opportunity of employment and practice in the medical field;
4. affirms its commitment to the full involvement of women in leadership roles throughout the federation, and encourages all components of the federation to vigorously continue their efforts to recruit women members into organized medicine;
5. acknowledges that mentorship and sponsorship are integral components of one’s career advancement, and encourages physicians to engage in such activities;
6. declares that compensation should be equitable and based on demonstrated competencies/expertise and not based on personal characteristics;
7. recognizes the importance of part-time work options, job sharing, flexible scheduling, re-entry, and contract negotiations as options for physicians to support work-life balance;
8. affirms that transparency in pay scale and promotion criteria is necessary to promote gender equity, and as such academic medical centers, medical schools, hospitals, group practices and other physician employers should conduct periodic reviews of compensation and promotion rates by gender and evaluate protocols for advancement to determine whether the criteria are discriminatory; and
9. affirms that medical schools, institutions and professional associations should provide training on leadership development, contract and salary negotiations and career advancement strategies that include an analysis of the influence of gender in these skill areas.
Our AMA encourages: (1) state and specialty societies, academic medical centers, medical schools, hospitals, group practices and other physician employers to adopt the AMA Principles for Advancing Gender Equity in Medicine; and (2) academic medical centers, medical schools, hospitals, group practices and other physician employers to: (a) adopt policies that prohibit harassment, discrimination and retaliation; (b) provide anti-harassment training; and (c) prescribe disciplinary and/or corrective action should violation of such policies occur.

Underrepresented Student Access to US Medical Schools H-350.960
Our AMA: (1) recommends that medical schools should consider in their planning: elements of diversity including but not limited to gender, racial, cultural and economic, reflective of the diversity of their patient population; (2) supports the development of new and the enhancement of existing programs that will identify and prepare underrepresented students from the high-school level onward and to enroll, retain and graduate increased numbers of underrepresented students; (3) recognizes some people have been historically underrepresented, excluded from, and marginalized in medical education and medicine because of their race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality, due to racism and other systems of exclusion and discrimination; (4) is committed to promoting truth and reconciliation in medical education as it relates to improving equity; (5) recognizes the harm caused by the Flexner Report to historically Black medical schools, the diversity of the physician workforce, and the outcomes of minoritized and marginalized patient populations; (6) will urge medical schools to develop or expand the reach of existing pathway programs for underrepresented middle school, high school and college aged students to motivate them to pursue and prepare them for a career in medicine; (7) will encourage collegiate programs to establish criteria by which completion of such programs will secure an interview for admission to the sponsoring medical school; (8) will recommend that medical school pathway programs for underrepresented students be free-of-charge or provide financial support with need-based scholarships and grants; (9) will encourage all physicians to actively participate in programs and mentorship opportunities that help expose underrepresented students to potential careers in medicine; and (10) will consider quality of K-12 education a social determinant of health and thus advocate for implementation of Policy H-350.979. (1) (a) encouraging state and local governments to make quality elementary and secondary education available to all.

Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Our AMA: (1) supports increased diversity across all specialties in the physician workforce in the categories of race, ethnicity, disability status, sexual orientation, gender identity, socioeconomic origin, and rurality; (2) commends the Institute of Medicine (now known as the National Academies of Sciences, Engineering, and Medicine) for its report, "In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce,” and supports the concept that a racially and ethnically diverse educational experience results in better educational outcomes; (3) encourages the development of evidence-informed programs to build role models among academic leadership and faculty for the mentorship of students, residents, and fellows underrepresented in medicine and in specific specialties;
(4) encourages physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine; (5) encourages medical schools, health care institutions, managed care and other appropriate groups to adopt and utilize activities that bolster efforts to include and support individuals who are underrepresented in medicine by developing policies that articulate the value and importance of diversity as a goal that benefits all participants, cultivating and funding programs that nurture a culture of diversity on campus, and recruiting faculty and staff who share this goal; and (6) continue to study and provide recommendations to improve the future of health equity and racial justice in medical education, the diversity of the health workforce, and the outcomes of marginalized patient populations.
RESOLUTION 112

SUBJECT: Medical Student Apportionment of Delegates

INTRODUCED BY: Board of Governors

WHEREAS, in August 2021 the Louisiana State Medical Society’s Medical Student Section had approximately 1,150 medical student members who paid no dues, and per the Society’s Bylaws they were entitled to a total of sixteen delegates to the LSMS House of Delegates, and

WHEREAS, R105-21 changed the dues structure for Medical Students where they receive their first year of LSMS membership free, followed by renewal dues of $10 per year while in medical school, and

WHEREAS, the LSMS anticipated a decrease in medical student membership and created an ad hoc committee to look at whether apportionment and representation in the House of Delegates should also be changed, and

WHEREAS, the ad hoc committee’s initial recommendation was to wait two years, see where medical student membership landed, and let the Board of Governors make a recommendation to the House of Delegates on any future changes, and

WHEREAS, currently the medical student section has 325 members, which represents a decrease of 72%, and

WHEREAS, sixteen delegates over represents the medical student section when compared to other sections such as the Young Physician Section (1 delegate), Private Practice Section (1 delegate), Employed Physician Section (1 delegate), and the Resident and Fellow Section (4 delegates), therefore be it

RESOLVED, that Article XII, Section A.11 of the LSMS Bylaws be amended to decrease the number of medical student delegates to the House of Delegates so that representation is aligned with membership, and be it further

RESOLVED, that the bylaws changes read as follows:

11. A total of sixteen five delegates from the Medical Student Section, as designated by the Medical Student Section, with one delegate representing each of the approved medical schools as delineated in Article IX (Membership Sections), Section 7.

Speaker Note: the five (5) medical schools delineated in Article IV, Section 7 of the LSMS Bylaws includes: LSU New Orleans, Tulane, Ochsner Queensland, LSU Shreveport and the Edward Via College of Osteopathic Medicine in Monroe.
RESOLUTION 113

Subject: AMA Delegation of the LSMS

Introduced by: Medical Student Section

WHEREAS, the Medical Student Section consists of 305 dues paying members of our LSMS, and

WHEREAS, the MSS has written a number of resolutions over the past years that have resulted in meaningful policy within our LSMS and the AMA, and

WHEREAS, there are currently eight delegate and/or alternate delegate positions within the LSMS for the delegation to the AMA\(^1\); and

WHEREAS, the LSMS Bylaws previously stated that there would be one member-in-training, that was dedicated for either a medical student or a resident on the AMA delegation, and

WHEREAS, Region 3 of the AMA-MSS consists of medical students from the states of Louisiana, Texas, Arkansas, Oklahoma, and Mississippi, and Kansas\(^2\), and

WHEREAS, it currently stands, within region 3 of the AMA-MSS, medical student representation from Louisiana has been disproportionately low, and

WHEREAS, it is known that getting involved in health policy as medical students is pivotal in developing leadership skills, getting familiar with health policy, and having a voice on a national platform, and

WHEREAS, limitations in funding have been a strong barrier for medical student involvement in the AMA delegation, and other national positions, therefore be it

RESOLVED, the LSMS Bylaws article XVI titled “AMA Delegation” Section B. “Selection” be amended by addition as follows:

ARTICLE XVI: AMA Delegation
B. Selection
Members of the AMA Delegation shall be elected in the same manner as specified for the election of officers in Article V Subsection B of these bylaws, except that if more than one vacancy is to be filled, those nominees in a number equal to the vacancies receiving the greatest number of votes would be elected.
One of the Alternate Delegate positions on the AMA Delegation shall be filled by the current LSMS President, and **one of the Alternate Delegate positions on the AMA Delegation shall be filled by a member of the Medical Student Section as nominated by the section.**

References:
RESOLUTION 114

SUBJECT: To commend Louisiana State Medical Society Medical Student Section for their attention and contribution to the future of medicine in the State of Louisiana

INTRODUCED BY: Jamie Kuo, MD

WHEREAS, Louisiana State Medical Society’s Medical Student Section (LSMS-MSS) was established to serve as a unified voice for students in the state.

WHEREAS, the LSMS-MSS represents five medical schools in Louisiana: • LSUHSC-New Orleans; • LSUHSC-Shreveport; • Tulane University School of Medicine; • University of Queensland Ochsner Clinical School; • VCOM-Louisiana Campus (Monroe)

WHEREAS, the LSMS-MSS objectives are to advocate for medical student training in Louisiana; provide a forum for the exchange of ideas and education on issues related to health policy; facilitate programs and services to help educate medical students on the professional aspect of medicine, organizing students to write resolutions, and to serve the LSMS and its policies

WHEREAS, the LSMS-MSS elects 16 (sixteen) delegates to the annual LSMS House of Delegates

WHEREAS, the LSMS-MSS is highly engaged and involved with LSMS as busy medical students.

WHEREAS, the LSMS-MSS members are likely to serve on LSMS leadership and committees as resident physicians and attending physicians.

WHEREAS, the LSMS-MSS members are the future leaders and representatives of Louisiana physicians, therefore be it

RESOLVED, that the Louisiana State Medical Society does hereby commend the Medical Student Section for their efforts to create the health care system they will inherit and for their tenacity at the annual House of Delegates.
RESOLUTION 115

SUBJECT: Changing Important Dates Relative to the House of Delegates

INTRODUCED BY: Board of Governors

WHEREAS, the final planning and execution of a House of Delegates cannot be finalized until such time as the Speakers and staff know how many delegates may be attending, and

WHEREAS, the order of business cannot be scheduled until such time the total number of resolutions is known, and

WHEREAS, it takes all parties involved a considerable amount of time to identify and confirm delegate participation, and

WHEREAS, it takes the Speakers and staff a considerable amount of time to format resolutions and the handbook, therefore, be it

RESOLVED, that the resolution deadline be moved up from 45 to 75 days prior to the meeting of the House of Delegates, and be it further

RESOLVED, that Article XII, Section H(2) of the LSMS Bylaws be amended as follows to facilitate this change. To be considered as regular business, resolutions must be presented in writing to the Speaker of the House of Delegates not later than 75 45 days before the opening session of a meeting of the House of Delegates. Resolutions presented later than 75 45 days before the opening session of a meeting of the House will be considered as new business only if:

a. Presented by the President of the Society;
b. Presented by the Board of Governors;
c. Decreed to be of an emergency nature by a committee composed of the President, the Speaker of the House, and the Vice Speaker of the House; or
d. Accepted by a two-thirds vote of the House of Delegates, provided that, before any such resolution shall come before the House of Delegates for action toward acceptance as a late resolution, the resolution must have been presented to the Committee on Rules and Order of Business for their consideration and recommendation.

Only the resolved portion of a resolution becomes official policy of the Society if the resolution is adopted; and be it further
RESOLVED, that the apportionment date for calculating delegate representation be moved from 75 to 180 days prior to the opening date of the House of Delegates, and be it further

RESOLVED, that Article XIX, Section E of the LSMS Bylaws be amended as follows. LSMS Delegates to the House of Delegates of the Louisiana State Medical Society are apportioned based on the recorded membership in the office of the LSMS Secretary-Treasurer seventy-five (75) one hundred eighty (180) days prior to the opening session of a meeting of the House of Delegates.

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RESOLUTION 116

SUBJECT: Modernization of the House of Delegates #1

INTRODUCED BY: Board of Governors

WHEREAS, the House of Delegates is the legislative and policy-making body of the Society, and

WHEREAS, each year new and returning delegates attend the House of Delegates to craft new legislative directives and policies, and

WHEREAS, many delegates in the House of Delegates have become increasingly disenfranchised by the extraordinary amount of time spent on administrative bylaw changes as opposed to substantive language relative to legislation and policy, and

WHEREAS, approximately 50% of all recent resolutions contained a bylaw change, which consumed more than half of the time allotted for the House to conduct its business, and

WHEREAS, these bylaws changes are internal or administrative in nature and have little to no impact on a physician delegates’ practice, patients, or medicine in general, and

WHEREAS, the House spends an extraordinary amount of time, effort, and energy wordsmithing bylaw changes even though the LSMS has a standing Charter and Bylaws Committee, charged, in part, to receive all proposed amendments to the Charter and Bylaws for review and perfection of language to implement, and

WHEREAS, the Charter and Bylaws Committee may and should review and wordsmith all bylaw changes in advance of the House of Delegates, thus creating efficiencies and allowing delegates to focus on policy and legislation, and

WHEREAS, this will allow for better use of time and space, permitting the LSMS to hold an annual meeting each year with the House of Delegates being a breakout session as part of a larger meeting, therefore be it

RESOLVED, that all resolutions and/or actions of the LSMS House of Delegates, Board of Governors, Officers, District Councilors, Sections, Councils, and Committees, that facilitate a Bylaws change will become the business of the LSMS Charter and Bylaws Committee, and be it further
Resolved, that the Charter and Bylaws Committee will present draft bylaw changes to the House of Delegates via a consent calendar, requiring two-thirds vote by the House for approval, and be it further

Resolved, that any recommendation from the Charter and Bylaws Committee may be extracted from the consent calendar by a delegate to the House of Delegates for debate and an up or down vote but the language from the committee may not be amended, and be it further

Resolved, any extracted bylaw change will require a two-thirds vote to reject, and the rejected language will be returned to the Charter and Bylaws Committee, who may reintroduce the proposed changes, with or without, additional edits at a subsequent meeting of the House of Delegates, and be it further

Resolved, that Article X, Section C “Committees of the Louisiana State Medical Society” of the Bylaws be amended as follows to facilitate these changes.

1. Members
   The Committee on Charter and Bylaws shall be composed of six seven members, who must be delegates to the House of Delegates. The members of the committee are appointed elected by the House of Delegates President. The Speaker and Vice-Speaker of the House of Delegates shall serve ex-officio without the power to vote.

2. Term
   Committee members are elected appointed for a term of three two years, staggered so that approximately one half of the committee is elected each year. A member may serve a maximum of four terms, serving from the time of their appointment until the appointment of their successor. A committee member may be reappointed for succeeding terms at the discretion of the President. One third of the members of the committee are appointed each year. The chair is appointed for a term of one year, serving from the time of his or her appointment until the appointment of his successor. The chair may be reappointed for succeeding terms at the discretion of the President. A committee member with more than two unexplained absences during his or her term will be dropped from the committee roster. A committee member not in attendance at the HOD will be presumed to have resigned unless he or she has a valid excuse, subject to the approval of the committee. A vacancy, whether due to death, disability severe enough to prevent fulfillment of duties, resignation, or removal, shall be filled by an appointee approved by the Board of Governors, of the President.

3. Organization
   The committee shall select its own chair. The term of the chair is one year. The chair may serve more than one term but no more than three terms consecutively. The committee shall formulate its own rules of procedure. These rules must not conflict with the rules of the House of Delegates or with the rules of the Louisiana State Medical Society. The President designates the chair of the committee.

4. Meetings
The committee shall meet at the call of the chair. **Four** three members shall constitute a quorum.

5. Duties
   a. To serve as a fact-finding and advisory committee on matters pertaining to the Charter and Bylaws of the LSMS;

   b. To evaluate and recommend to the House of Delegates and the Board of Governors the guidelines and rules that establish the authoritative direction or control of the conduct and affairs of the corporate and policy-making bodies of the Society;

   c. To periodically review the Charter and Bylaws, and other adopted rules of the LSMS and initiate the process of amending such when indicated.

   d. To receive all proposed amendments to the Charter and Bylaws for review and perfection of language to implement the actions of the House of Delegates.

   e. **To submit draft bylaw changes to the House of Delegates for approval in the form of a consent calendar.**

   f. To issue interpretations of meaning of the Charter and Bylaws and other adopted rules when requested by the President, the Board of Governors, or the House of Delegates.

   g. To review the bylaws of Chartered Parish Societies as to compliance with the Charter, Bylaws, or other adopted rules of the LSMS, and be it further

   **RESOLVED,** that Article XXX of the LSMS Bylaws “Amendments” be amended as follows:

   These Bylaws may be amended **by the LSMS Charter and Bylaws Committee upon** approval of two-thirds of the members of the House of Delegates present and voting.
RESOLUTION 117

SUBJECT: Modernization of the House of Delegates 2

INTRODUCED BY: Board of Governors

WHEREAS, the business of medicine, including the business traditionally handled within the LSMS House of Delegates, moves exponentially quicker than it once did, and

WHEREAS, participation in the LSMS House of Delegates has decreased to approximately 40% over the last fifteen years from 170 delegates in 2007 to just 103 in 2022, and

WHEREAS, the definition of a quorum has been changed or interpreted many ways in recent years for the House to conduct its business, and

WHEREAS, holding a stand-alone House of Delegates meeting places an unnecessary financial burden on the LSMS, and

WHEREAS, holding an annual meeting allows for increased participation, registration fees, sponsors, exhibitors, educational sessions, speakers, social functions, a business meeting, and

WHEREAS, the LSMS Bylaws already allow for an annual meeting and a House of Delegates, therefore be it

RESOLVED, that beginning in 2024, the House of Delegates shall function as a smaller break out session(s) within a larger annual meeting of the society, and be it further

RESOLVED, that the annual meeting will host the House of Delegates in addition to other events such as educational seminars, speakers of interest, panel discussions, section meetings, etc., and be it further

RESOLVED, that a registration fee will be collected to attend the Annual Meeting of the LSMS but not for delegates who choose only to attend the House of Delegates section(s) of the meeting. However, individual tickets to social functions may be purchased outside of annual meeting registration fees, by delegates and other guests, and be it further

RESOLVED, that the LSMS President create an ad hoc committee who shall work in tandem with staff to develop the budget, cost, content, schedule, etc. for the 2024 annual meeting.
RESOLUTION 118

SUBJECT: Non-Compete Covenants

INTRODUCED BY: Board of Governors

WHEREAS, unreasonable covenants not-to-compete, such as many used by hospitals and/or hospital systems, may restrict competition and limit access to care, and

WHEREAS, these same non-compete covenants also lead to physician shortages in many areas of the state, and

WHEREAS, physician owners of independent private practices invest substantially in recruitment, hiring and training of physicians, and

WHEREAS, private physician practices must use reasonable restrictive covenants to compete with hospital systems and institutional employers, and

WHEREAS, preserving, fostering, and supporting independent physician practices is critical to maintaining access to patient care in Louisiana, and

WHEREAS, our current LSMS policy related to non-compete covenants (213.18) handcuffs our legislative staff and their efforts regarding non-compete covenants when opposing them in general, and

WHEREAS, the Federal Trade Commission (FTC) is currently reviewing non-compete covenants and will ultimately determine whether it bans them at the federal level, therefore be it

RESOLVED, that LSMS policy 213.18 be sunset, and that LSMS convene an ad hoc committee comprised of independent physicians, employed physicians, and medical group managers to better shape our policy regarding non-compete covenants with a report back to the House of Delegates at the 2024 meeting, and be it further

RESOLVED, that the LSMS adopt interim policy opposing unreasonable non-compete and restrictive covenants in physician contracts, and be it further

RESOLVED, that for the 2024 legislative session, the Council on Legislation is given the authority to individually review any legislation specific to these contract clauses and make a determination on each instrument until such time that a final decision has been rendered by the FTC, and our House has received a final report from our ad hoc committee at the 2024 annual HOD, and be it further

RESOLVED, that LSMS takes no proactive action regarding non-compete covenants until such time that a final decision on these covenants has been rendered by the FTC, and our House has received a final report from our ad hoc committee at the 2024 annual HOD.

Speaker Note: LSMS Policy 213.18: the LSMS opposes non-compete and restrictive covenants in employer contracts for physicians and supports efforts to prohibit enforceability of existing physician non-compete agreements in Louisiana.