2020

Medical Association of Georgia

Building a Better State of Health Since 1849

POLICY COMPENDIUM

166th House of Delegates

October 17-18, 2020

Medical Association of Georgia

Building a Better State of Health Since 1849

2020 Policy Compendium

Current policies of the Medical Association of Georgia (MAG) House of Delegates, Board of Directors, and Executive Committee

MAG Annual Session Committee in cooperation with the Committee on Constitution and Bylaws, Board of Directors Office of Executive Director/CEO

August 10, 2020

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Foreword

We are pleased to present the 2019 Medical Association of Georgia (MAG) Policy Compendium. The Compendium provides a complete listing of MAG's permanent policies. This publication serves as a valuable resource for MAG's policy communication efforts and provides the informational foundation for the Association's policy research and development activities. The book and computer database program are both an essential reference for preparation of reports and resolutions to the MAG House of Delegates and discussion of policy issues before the MAG House.

The Compendium includes the policies adopted by the MAG House of Delegates, the Board of Directors and the Executive Committee. It does not contain the supporting documentation used by the House of Delegates to debate issues; items that were referred, filed, or not adopted; temporary policy directives (e.g., that a specific, immediate action be taken or that a study be conducted); reports that merely summarize policy implementation activities; legislative and regulatory statements or testimony; and appointments, awards, or commendations.

The reference numbering system is consistent with AMA's Policy Compendium allowing easy reference to topic areas.

The first section of documents includes the Principles of Medical Ethics, the Fundamental Elements of the Patient/Physician Relationship and the Constitution and Bylaws of the Medical Association of Georgia, followed by the policy statements.

This edition of the Compendium presents policies dated through the 2019 House of Delegate meetings and Board of Directors and Executive Committee meetings as of January 2020.

Acknowledgements

A number of committee members and other individuals have made significant contributions to the development of this edition of the Compendium. The Committee thanks the following people who made significant contributions to this volume: Donald Palmisano, Jr., who serves as Editor, Bethany Sherrer, who serves as Editorial Advisor and Donna Glass who prepares the policy statements, enters the actions and policies, and maintains the MAG Action Database.

The members of the MAG Annual Session Committee who provide oversight to the *Policy Compendium* include:

Speaker of the House: Edmund Donoghue, Savannah (Pathology) CHAIR
Vice Speaker of the House: James W. Barber, Douglas (Orthopedic Surgery) V CHAIR
President: Andrew B. Reisman, Oakwood, (Family Physician)
President-Elect: Lisa Perry-Gilkes, Atlanta, Otolaryngology
Immediate Past President: Rutledge Forney, Atlanta (Dermatology)
Steven M. Walsh, Roswell (Anesthesiology) at-large member (Anesthesiology)
MAG Alliance: Dave Street, President

Principles of Medical Ethics

The Principles of Medical Ethics are the primary component of the American Medical Association's Code of Ethics which are also adhered to by the Medical Association of Georgia. They establish the core ethical principles from which the other components of the Code are derived. The Principles were revised most recently in 2001.

No one Principle of Medical Ethics can stand alone or be individually applied to a situation. In all instances, it is the overall intent and influence of the Principles of Medical Ethics that shall measure ethical behavior for the physician. The AMA's Council on Ethical and Judicial Affairs' opinions are issued under its authority to interpret the Principles of Medical Ethics and to investigate general ethical conditions and all matters pertaining to the relationship of physicians to one another and to the public.

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.

II. A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

V. A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care.

VII. A physician shall recognize a responsibility to participate in activities contributing to the improvement of the community and the betterment of public health.

VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

IX. A physician shall support access to medical care for all people.

Fundamental Elements of the Patient-Physician Relationship

Adopted by the AMA in 1990 and updated in 1993, Fundamental Elements of the Patient-Physician Relationship enunciates the basic rights to which patients are entitled from their physicians.

From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient. Patients share with physicians the responsibility for their own health care. The patient-physician relationship is of greatest benefit to patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance. Physicians can best contribute to this alliance by serving as their patients' advocate and by fostering these rights:

1. The patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives. Patients should receive guidance from their physicians as to the optimal course of action. Patients are also entitled to obtain copies or summaries of their medical records, to have their questions answered, to be advised of potential conflicts of interest that their physicians might have, and to receive independent professional opinions.

2. The patient has the right to make decisions regarding the health care that is recommended by his or her physician. Accordingly, patients may accept or refuse any recommended medical treatment.

3. The patient has the right to courtesy, respect, dignity, responsiveness, and timely attention to his or her needs.

4. The patient has the right to confidentiality. The physician should not reveal confidential communications or information without the consent of the patient, unless provided for by law or by the need to protect the welfare of the individual or the public interest.

5. The patient has the right to continuity of health care. The physician has an obligation to cooperate in the coordination of medically indicated care with other health care providers treating the patient. The physician may not discontinue treatment of a patient as long as further treatment is medically indicated, without giving the patient reasonable assistance and sufficient opportunity to make alternative arrangements for care.

6. The patient has a basic right to have available adequate health care. Physicians, along with the rest of society, should continue to work toward this goal. Fulfillment of this right is dependent on society providing resources so that no patient is deprived of necessary care because of an inability to pay for the care. Physicians should continue their traditional assumption of a part of the responsibility for the medical care of those who cannot afford essential health care. Physicians should advocate for patients in dealing with third parties when appropriate. (I, IV, V, VIII, IX) Issued June 1992 based on the report "Fundamental Elements of the Patient-Physician Relationship," adopted June 1990 (JAMA. 1990; 262: 3/33); Updated 1993.

CONSTITUTION AND BYLAWS
OF THE MEDICAL ASSOCIATION OF GEORGIA

AS REVISED BY THE HOUSE OF DELEGATES AT THE
2019 ANNUAL SESSION

(Supersedes any MAG C&B prior to October 20, 2019)

C O N S T I T U T I O N

ARTICLE I - NAME OF THE ASSOCIATION

The name of this organization is the Medical Association of Georgia.

ARTICLE II - OBJECTIVES OF THE ASSOCIATION

The objectives of the Association are to promote the science and art of medicine and the betterment of public health as provided for in the Bylaws.

ARTICLE III - MEMBERSHIP

The Medical Association of Georgia is composed of individual physician members and others as specified in the Bylaws. A member shall retain membership as long as a member complies with the provisions of the Constitution and Bylaws of this Association.

ARTICLE IV - HOUSE OF DELEGATES

The House of Delegates is composed of elected representatives from county medical societies, medical specialty societies and others as determined by the Bylaws. All delegates' qualifications and terms of office shall be provided for in the Bylaws.

The House of Delegates is the legislative body of the Association responsible for determining the policy of the Association, and it shall transact all business of the Association not otherwise specifically provided for in this Constitution and Bylaws.

ARTICLE V - BOARD OF DIRECTORS

The Board of Directors is composed of Directors as provided for in the Bylaws. All Directors' qualifications and terms of office shall be provided for in the Bylaws. The Board of Directors is the Board of Trustees of the Association. It carries out the mandates and policies as determined by the House of Delegates between sessions of that body. The Board of Directors has charge of all property and financial affairs of the Association and performs such duties as are prescribed by law governing directors of corporations and as may be prescribed in the Bylaws.

ARTICLE VI - GENERAL OFFICERS

The general officers of the Association shall be a President, President-Elect, Immediate Past

President, First Vice President, Second Vice President, Secretary, Treasurer, Speaker of the House of Delegates, Vice Speaker of the House of Delegates, Directors and Alternate Directors. Their qualifications and terms of office shall be provided for in the Bylaws.

ARTICLE VII - MEETINGS

The House of Delegates shall meet annually and at such other times as provided in the Bylaws.

ARTICLE VIII - FUNDS AND EXPENDITURES

Funds for the Operation of the Association shall be raised as provided in the Bylaws. The amount of any member dues or assessment shall be set by the House of Delegates upon recommendation of the Board of Directors. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the Board of Directors. The Board of Directors shall approve the annual budget, manage finances of the Association, and submit a report on the budget and the management of the Association’s finances to the House of Delegates.

ARTICLE IX - OFFICIAL PUBLICATION

There shall be an official publication of the Association as determined by the House of Delegates.

ARTICLE X - SEAL

The Association shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XI - AMENDMENTS

The House of Delegates may amend this Constitution at any session by a two-thirds vote of the delegates present, provided that the proposed amendment shall have been introduced in the preceding annual session and provided that the proposed amendment shall have been published during the year in the official publication of the Association.

B Y L A W S

CHAPTER I - GOVERNING PRINCIPLES AND ETHICS OF THE ASSOCIATION

SECTION 1. GOVERNING PRINCIPLES. The objectives of the Association are specified in Article II of the Constitution. In order to attain these objectives, the Association shall undertake at all times to aspire and adhere to the following governing principles:

(a) Coordination of physicians of Georgia of common professional background into a cohesive organization, and unification with other such associations in other states to form the American Medical Association.

(b) Service to its membership;

(c) Promotion of the art and science of medicine among its members for the benefit of the citizens of Georgia;

(d) Maintenance and assurance of the highest quality of medical care by its members;

(e) Representation of its membership faithfully in dealing with government, other organizations and the public;

(f) Adherence to the Principles of Medical Ethics set forth by the American Medical Association.

SECTION 2. ETHICS

(a) Ethics. The principles and ethics of the American Medical Association, the Association's Constitution and Bylaws (as now set forth or as may be hereafter amended) and the standards of the profession in Georgia shall govern the conduct of the members of the Association, unless otherwise rejected, modified or changed by the Board of Directors or the House of Delegates which shall then become the official position of the Association. As specific questions of principles and ethics develop, pronouncements from the Medical Association of Georgia (“MAG”) would be paramount.

CHAPTER II - MEMBERSHIP

SECTION 1. ACTIVE MEMBERS.

(a) A physician may become an Active Member in the Association by submitting a completed membership application and application fee to the Association and having that application approved by the Association. In addition a physician applying for membership as an Active Member must hold the degree of Doctor of Medicine, Doctor of Osteopathy or Bachelor of Medicine or an equivalent degree issued in a foreign country from a medical college acceptable to the Judicial Council of the Association and must meet the requirements of subparagraphs (i), (ii), or (iii) below:

(i) Be licensed to practice medicine in the State of Georgia; or

(ii) Be employed as an intern, resident or fellow in a hospital or institution whose internship, residency or fellowship program is approved by the Composite State Board of Medical Examiners of Georgia or any predecessor or successor body authorized to license Doctors of

Medicine; or

(iii) Be employed as a commissioned medical officer in any of the armed forces of the United States or in the United States Public Health Service, Veterans Administration or Indian Service.

(b) Those members classified under subparagraphs (i) and (iii) above shall pay full annual dues and assessments to the Association; and those members classified under subparagraph (ii) above shall pay dues and assessments, as determined by the House of Delegates. All members described in this Section 1 shall have full privileges of membership, including the right to vote, to hold office and to receive the official publication of the Medical Association of Georgia, except as expressly set forth in these Bylaws.

(c) An Active Member may be excused from the payment of dues or assessments for financial hardship or illness. Such dues or assessments exemption may be granted or denied by the Judicial Council after recommendation of the member's component local society or, in the case of a Direct Member, by the Executive Committee of the Medical Association of Georgia. Within 30 days after each anniversary of the date that such an exemption is granted, the Judicial Council shall review such member's exemption status and determine if it is still warranted based on the member's financial or medical condition. Upon such review, including consulting with the member's component local society, the Judicial Council may grant an extension of the member's dues exempt status or terminate that status. Members excused from the payment of dues or assessments pursuant to the above shall continue to receive all rights and benefits of membership as enjoyed by active dues paying members.

(d) A physician who holds a degree of Doctor of Medicine, Doctor of Osteopathy or an equivalent degree issued in a foreign country by a medical college acceptable to the Judicial Council of the Association, who is licensed to practice medicine in the State of Georgia, and who pays the dues and assessments appropriate to his or her category of membership as set by the House of Delegates may elect to become a Direct Member. Direct Members are not members of the county medical societies.

SECTION 2. RETIRED MEMBERS. A member who elects to retire from the practice of medicine regardless of age or length of membership in this Association may do so and be classified as a retired member. Retired members shall not be entitled to vote, hold office or receive any publication of the Association except by personal subscription. Retired physicians shall be defined as those who have indicated their retirement in writing to the MAG Secretary and practice less than 20 hours per week. All members classified as Retired Members prior to December 31, 2002 shall be excused from payment of Association dues and assessments. All members who are eligible for Retired Membership after December 31, 2002 will be assessed dues to be determined by the House of Delegates.

SECTION 3. OUT-OF-STATE MEMBERS. Out of State Members are defined as those physicians who are licensed in Georgia, who meet the membership criteria of Chapter II, Section 1(a)(i), but who practice the majority of their professional time in another State. The Board will set the amount of dues for Out of State Members. Out of State Members of MAG may be solicited by GAMPAC for contributions but will not have the right to vote, hold office or receive the Journal of the MAG or other benefits, unless accorded by the House of Delegates or the MAG Board of Directors. Out of State Members of MAG will have the right to join county medical societies but not count towards their delegate allotment to the MAG House of Delegates.

SECTION 4. SERVICE MEMBERS. A physician may become a Service Member by being a commissioned medical officer in any of the armed forces of the United States or by having retired from gainful employment as a medical officer of the United States Public Health Service, Veterans Administration, Indian Service, or Armed Forces. Service Members need not be licensed to practice medicine in the State of Georgia provided they hold the degree of Doctor of Medicine, Doctor of

Osteopathy or Bachelor of Medicine or an equivalent degree issued in a foreign country from a medical college acceptable to the Judicial Council. Such members shall not be required to pay any dues to the Association. They shall not be entitled to vote or hold office in the Association, nor shall they receive any publications of the Association except by personal subscription.

SECTION 5. ASSOCIATE MEMBERS. Physicians may become Associate Members of MAG when they are recommended by their component medical societies or by the Executive Committee of the Medical Association of Georgia and they have met the criteria for Associate Members as established by the MAG Executive Committee. Associate Members need not be licensed to practice medicine in the State of Georgia. Associate Members may not vote nor hold office except that they may vote when serving as members of MAG committees on issues submitted to a vote of such committees.

SECTION 6. AFFILIATE MEMBERS. Persons in the following classes may become Affiliate Members:

(a) American physicians located in foreign countries or possessions of the United States, and engaged in medical missionary and similar education and philanthropic labors;

(b) Dentists, who hold the degree of D.D.S. or D.M.D., who are members of their state and local dental societies;

(c) Pharmacists who are active members of the Georgia Pharmacy Association;

(d) Veterinarians who hold the degree of D.V.M. and are members of the Georgia Veterinary Medical Association;

(e) Teachers of medicine who are not eligible for active membership.

All nominations must be made by the component county medical societies or the Executive Committee of the Medical Association of Georgia and approved by the Judicial Council of MAG.

Affiliate Members shall not be required to pay membership dues, and shall enjoy the privileges of the scientific meetings. Affiliate Members shall not have the right to vote or hold office, and shall not be entitled to receive any publication of the Association, except by personal subscription.

SECTION 7. HONORARY MEMBERS. Physicians and other persons who have risen to prominence in their professions may be elected to honorary membership by the House of Delegates. Nominations for honorary membership may be submitted to the House of Delegates by component county societies or the Judicial Council. These members shall enjoy the privileges of the Association but shall not vote or hold office; nor shall they receive any publication of the Association except by personal subscription.

SECTION 8. LIFE MEMBERS. A member in good standing who is 70 years of age (on or by January 1 of the current dues year) may be classified as a Life Member if the physician has been an active, dues paying member of any state medical society for at least 25 consecutive years and has been an active, dues paying member of this Association for at least two of those years and has notified the secretary of the Association his/or her desire to be reclassified as such. Service in the Armed Forces during a national emergency or compulsory service under the Selective Service System or temporary service as a full-time commissioned medical officer in the Reserve Armed Forces shall count as part of the period of continuous years of dues-paying membership. All members classified as Life Members shall be excused from payment of Association dues and assessments. These members shall continue to receive the official publication of the Medical Association of Georgia without cost. All Life Members will be polled on an annual basis to determine whether they wish to continue to receive publications and make a contribution.

SECTION 9. STUDENT MEMBERS. Any person may become a Student Member of this Association upon proof that such person is a student in good standing at a medical school approved by the Liaison Committee on Medical Education or the Committee on Colleges, the Commission on Osteopathic College Accreditation (COCA) of the American Osteopathic Association. Student Members may not vote nor hold office except that they may vote when serving as members of MAG committees on issues submitted to a vote of such committees, and when serving as a voting Delegate representing the Medical Student Section in the House of Delegates and when serving as a voting Director representing the Medical Student Section on the Board of Directors.

SECTION 10. EXPULSION AND REINSTATEMENT

(a) Expulsion. Any applicant to or present member of MAG judged guilty of a crime involving moral turpitude, or convicted of a felony, or whose license has been suspended or revoked by the Composite State Board of Medical Examiners shall be immediately referred to the Judicial Council who will recommend whether that physician should be expelled from MAG or denied admission to MAG.

Upon MAG's receipt of official written notice from the component society or from the Executive Committee of the Medical Association of Georgia that a member has been judged guilty of a crime involving moral turpitude, or convicted of a felony, or upon notice from the Composite State Board of Medical Examiners that a member's license to practice has been suspended or revoked, that physician's name shall be referred to the Judicial Council to determine if that physician should remain a member of MAG.

(b) Reinstatement. Any physician interested in being reinstated as a member of MAG shall be reinstated at the discretion of the MAG Judicial Council. Documents that may be considered by the Judicial Council, include, but are not limited to, a recommendation for membership or reinstatement from that person's component county medical society or, in the case of a Direct Member, from the Executive Committee of the Medical Association of Georgia, and upon satisfaction of all other MAG membership requirements.

A member expelled from membership in the Association shall have none of its privileges during the period or after expulsion.

SECTION 11. JURISDICTION

(a) It shall be the policy of this Association and its component county medical societies that its members who belong to a component county medical society shall belong to the component society that is based in the county where the physician resides or has his or her practice of the county contiguous to his or her residence or practice location.

(b) If physicians reside and/or practice in other states, they may belong to county medical societies in Georgia, as long as they are members of and in good standing in the state medical associations in their states of dominant practice. Such membership shall be applied for through the county medical society in Georgia with which they wish to affiliate, and all business shall be conducted through that county society and not MAG.

(c) If a member of MAG maintains multiple active component county medical society memberships, it is the duty and responsibility of the physician member to notify the Secretary of the Association via regular or electronic mail 45 days prior to the opening of the annual MAG House of Delegates meeting as to which component county medical society the MAG member should be counted

for MAG Delegate entitlement and Director entitlement purposes. Failure to comply with this notification requirement will result in the MAG member being automatically assigned to the component society of his or her residence.

(d) If a member of MAG temporarily moves to another state for continuing education, fellowship, additional residency, military service, or other reasons approved by the member's county medical society, the member may continue membership in MAG as long as the physician remains a member in good standing.

CHAPTER III - COMPONENT COUNTY SOCIETIES

SECTION 1. COUNTY SOCIETIES. A component county society shall consist of five or more active members and shall be chartered by the Association. Only one component county society shall be chartered in each county. In sparsely populated areas the House of Delegates shall have authority to organize the physicians of two or more counties into societies to be designated so as to distinguish them from district societies. These multi-county societies when chartered shall be entitled to all the rights and privileges provided for component county societies.

SECTION 2. NAMES OF SOCIETIES. The names and titles of each component county society shall read exactly as found in its charter. No change in such names shall be made without the approval of the House of Delegates of the Medical Association of Georgia.

SECTION 3. CHARTER. All county societies which have adopted principles of organization in conformity with the Constitution and Bylaws of the Medical Association of Georgia and whose constitution and bylaws have been submitted to and approved by the Board of Directors of the Association may receive charters. Such charters shall be provided and issued by the House of Delegates and signed by the President and Secretary. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of the Association's Constitution and Bylaws. Any component county society whose dues forwarded to the Association total less than five members for 12 consecutive full calendar months shall have its charter automatically revoked as of the next calendar year. Any society whose charter is thus automatically revoked may apply for a new charter by following the procedures established above.

SECTION 4. CUSTODY OF CHARTER. The charter of each component county society as issued by the Medical Association of Georgia shall be preserved in the custody of the secretary of such society at all times.

SECTION 5. PURPOSES. Each component county society shall promote the science and art of medicine and the betterment of public health in the county, constantly exerting its influence for bettering the scientific, moral, and material conditions of its members. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every acceptable and eligible physician in the county or counties in its jurisdiction.

SECTION 6. DUTIES. Each component county society shall meet the minimum standards set forth in this Section. Each society shall: (a) meet one or more times a year, elect officers and select its delegates annually and report these officers to the headquarters office; (b) maintain an up-to-date constitution and bylaws in conformity with the Constitution and Bylaws of the Medical Association of Georgia and submit a copy of its constitution and bylaws, along with any amendments thereto, to the headquarters office for the Association's records; (c) maintain a Board of Censors and/or a Mediation Committee; (d) maintain minutes of each meeting in a permanent record book that will be available for inspection at all times; (e) maintain an accurate and up-to-date roster of its members and promptly notify the Association of any

additions to or deletions from its membership; and (f) notify the Association of any action taken by the society or action known to the society taken by any other body which affects any member's eligibility for membership in the Association.

SECTION 7. DISTRICT SOCIETIES. In order to promote the best interests of the profession, the House of Delegates shall provide for the division of the State into districts and for the organization of all component county societies in the districts into district medical societies.

District societies shall have one or more meetings during the year and shall elect a Director and an Alternate Director as provided in these Bylaws. These district societies shall be organized for the best interests of the medical profession in Georgia and shall not necessarily conform with the boundaries of congressional districts. District Societies shall elect officers, adopt a constitution and bylaws in conformity with the Constitution and Bylaws of the Medical Association of Georgia and levy dues for the government of its own affairs. All district society members shall be members in good standing with their county medical society and MAG.

In cases where a component county medical society substantially covers the same territory as a district society, no district society need be organized and all references in these Bylaws to district societies shall be deemed to refer in such instances to the appropriate component county medical societies.

SECTION 8. FAILURE TO MEET CHARTER REQUIREMENS. Where a county or district medical society fails to meet the requirements outlined in Section 6 under this chapter, MAG will operate the society as a subsidiary.

CHAPTER IV - GENERAL MEETINGS.

General meetings shall be held for the presentation and discussion of subjects pertaining to the science and art of medicine and the economic, regulatory and legislative issues that affect the practice of medicine. The general meetings shall be open to all members and guests who have complied with the applicable registration requirements.

CHAPTER V - HOUSE OF DELEGATES

SECTION 1. PURPOSE AND MEETINGS. The purpose of the House of Delegates is to be the chief policymaking and legislative body of the Association. The House of Delegates shall meet during the Annual Session at a time and place fixed by the Executive Committee. The House of Delegates may also meet in interim sessions and at such other times as may be necessary for the transaction of the business of the Association. The time and place of these interim sessions will be determined by the Board of Directors. All sessions of the House of Delegates may be attended by all members of the association; provided, however, that members of the association that are not delegates may attend executive sessions of the House of Delegates only with the prior approval of the Speaker.

Special meetings of either the Association or the House of Delegates may be called by a two-thirds vote of the Board of Directors or upon written petition of one-third of the delegates of the House of Delegates, or upon written petition of one-fourth of the members of the Association.

SECTION 2. COMPOSITION. The House of Delegates is composed of members selected by component county societies and other members as defined in subsections (b) and (c) of this section.

(a) Component County Societies. For each 25 members, or fraction thereof, whose dues have

been paid to the Association by December 31 of the preceding year, each component county society shall select, in accordance with their respective bylaws, one delegate and one alternate delegate, each of whom shall be a member in good standing of the Association, provided, however, that each component county society shall be entitled to at least one delegate and one alternate delegate. Life members shall be counted the same as dues paying members and included in the total for purposes of delegate apportionment. The secretary of each component society shall send a list of such delegates to be received by the Secretary of the Association not later than 45 days prior to the opening of the annual House of Delegates meeting.

(b) Sections: Each of the following sections are eligible to select delegates and alternate delegates who are not simultaneously serving as delegates or alternate delegates from any component county medical society or specialty society as provided in subsections (i-v):

(i) The Organized Medical Staff Section shall be comprised of physicians in large group physician-owned medical practices, physicians employed by any duly licensed hospital in Georgia, who holds a D.O. degree or an M.D. degree or its equivalent and who has an unrestricted license to practice medicine and surgery in Georgia, and is a member in good standing of the Medical Association of Georgia. The Section shall be entitled to one voting delegate and one alternate delegate.

(ii) The Resident Physician and Fellows Section shall be comprised of physicians who are serving in Georgia Residency or Fellowship Training programs approved by the Accreditation Council for Graduate Medical Education, or by the American Osteopathic Association, and who are members in good standing of the Medical Association of Georgia. The Section shall be entitled to one voting delegate and one alternate delegate.

(iii) The Medical Student Section shall be comprised of medical students who are student members of the Medical Association of Georgia, enrolled in Georgia medical schools that are accredited by the Liaison Committee on Medical Education, the Committee on Colleges, Bureau of Professional Education or American Osteopathic Association. The Section shall be entitled to one voting delegate and an alternate from each of the medical schools in Georgia which are accredited by the Liaison Committee on Medical Education.

(iv) The Young Physician Section shall be comprised of those active members of the Medical Association of Georgia who are under 40 years of age or within the first eight years of medical practice and are not residents or fellows. The Section shall be entitled to one voting delegate and one alternate delegate.

(v) The International Medical Graduate Section shall be comprised of Active members of the Medical Association of Georgia who are graduates of any medical college that is located in a foreign country and that is acceptable to the Judicial Council of the Association. The Section shall be entitled to one voting delegate and one alternate delegate.

(c) Specialty Societies. Each statewide specialty society representing a medical specialty recognized by the MAG Board of Directors, upon recommendation from the Executive Committee, and recognized by the American Board of Medical Specialties, shall be eligible for representation in the MAG House of Delegates if it contains at least 51 Active MAG members. Each such recognized specialty society shall be entitled to representation in the MAG House of Delegates in the following manner:

(i) Any such recognized specialty society having 51 to 200 Active MAG members shall be entitled to one delegate;

(ii) Any such recognized specialty society having 201 to 400 Active MAG members shall be entitled to two delegates; and

(iii) Any such recognized specialty society having more than 400 Active MAG members shall be entitled to three delegates.

If a recognized specialty society does not have 50 dues-paying specialty society members, it shall be entitled to one delegate if at least 60% of its members are Active MAG members. Any delegate representing a recognized specialty society must be a member in good standing of the Medical Association of Georgia, and not simultaneously a delegate or alternate delegate from any component county medical society or Section.

(d) The officers, the past presidents of the Association, the Editor of the Journal, delegates to the AMA and chairpersons of standing committees shall be ex-officio members of the House of Delegates without the right to vote.

(e) Vacancies: In the absence of, or the disability or disqualification of a Delegate from a county medical society, section or specialty society, the vacancy may be filled by the President or Secretary of the respective county medical society, section or specialty society from among the members of the same county medical society, section or specialty society who are members in good standing of the Medical Association of Georgia, and not simultaneously a delegate or alternate delegate from any component county medical society or section.

SECTION 3. QUORUM. Forty of the registered members of the House of Delegates shall constitute a quorum.

SECTION 4. SELECTION & TERMS OF DELEGATES.

(a) Component County Societies. Delegates to the House of Delegates shall serve for a term of one to three years as set forth in each component county medical society's respective bylaws.

(b) Sections. The Organized Medical Staff Section, Resident Physician and Fellows Section, Young Physician Section and International Medical Graduates Section shall select, in accordance with their respective policies and procedures, delegates annually from their membership. Medical Student Section delegates shall be selected by the section from the student representatives to the House of Delegates.

(c) Specialty Societies. Delegates shall be selected by their respective specialty societies in accordance with their specialty society's bylaws.

SECTION 5. ORGANIZATION

(a) Speaker of the House of Delegates and Vice Speaker of the House of Delegates. The House of Delegates shall be presided over by the Speaker, or in the absence of the Speaker, by the Vice Speaker. In the absence of the Vice Speaker, the Speaker may designate a delegate to serve in that capacity for the duration of the meeting. In the absence of both, the President shall nominate two delegates to serve as Speaker and Vice Speaker who the House of Delegates will confirm. The Speaker and Vice Speaker shall be elected every second year at the second session of the House of Delegates during the Annual Session, and their terms of office shall commence immediately upon the adjournment of the House of Delegates.

The duties of the Speaker of the House of Delegates shall be to: (1) preside over all meetings of

the House of Delegates; (2) serve as a member of the Board of Directors and the Executive Committee; (3) preserve order at all meetings of the House of Delegates and follow proper parliamentary procedure; (4) validate the representation of each component society by the Credentials Committee at the time of each meeting and to fill such vacancies as may occur as set forth in Chapter V, Section 2 of these Bylaws. Such temporary appointees shall be Medical Association of Georgia members of the component society having the vacancy; (5) appoint the House of Delegates Reference Committees, Credential Committee, Late Resolution Committee, Tellers, Parliamentarians, and any other committees considered necessary; (6) coordinate with the Executive Director regarding all aspects of the Annual Session such as times of events, staff allocation, and location of events; (7) chair the Annual Session Committee.

The Vice Speaker of the House shall: (1) assist the Speaker and preside over the House of Delegates in the absence of the Speaker. In the event of the Speaker's death, resignation, or inability to serve, the Vice Speaker shall succeed the Speaker for the unexpired term; (2) serve as a member of the Board of Directors and Executive Committee concurrent with that term of office.

(b) Secretary. The Secretary of the Association shall be the Secretary of the House of Delegates or, in the absence of the Secretary, a delegate appointed by the Speaker of the House of Delegates shall serve as Secretary of the House of Delegates.

(c) Committees. The Speaker of the House of Delegates shall appoint, from delegates and alternate delegates of the House of Delegates, the Reference Committees, the Credentials Committee, and other committees considered necessary for the proceedings of the House of Delegates. Any members of the Association may speak in a reference committee and attend open sessions of the House of Delegates as an observer. Any guests or non-members may attend and/or speak at reference committee meetings only with the permission of the Speaker. Any member of the Association may be appointed to serve on a committee created for a special purpose. Such members who are not delegates of the House of Delegates shall have the right to present their reports in person and to participate in debate but shall not have the right to vote.

SECTION 6. PROCEDURE. The deliberations of the Association shall be conducted in accordance with the current edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure unless contrary to the Association's Constitution and Bylaws or procedures of the House of Delegates.

(a) Order of Business. The general order of business at all meetings of the House of Delegates shall be: (1) call to order by the Speaker; (2) invocation and welcome; (3) introduction of guests; (4) Credentials Committee Report (5) adoption of the minutes; (6) nominations and elections of officers; (7) unfinished business; (8) new business. At any meeting, the House by majority vote may change the order of business. New business may be introduced at the final session of the House of Delegates only when such business is of an emergency nature or introduced by unanimous consent.

(b) Reports and Resolutions. All reports and resolutions received prior to the first session of the House of Delegates shall be referred by the Speaker to the appropriate reference committee before action is taken by the House of Delegates. Reports that contain no recommendations shall be referred at the discretion of the Speaker or upon a formal request for referral made by a Delegate from the floor of the House of Delegates. Reports that are not referred shall be filed and received for information only; provided, however, that the report of the annual budget and the management of the Association's finances shall be referred by the Speaker to the appropriate reference committee notwithstanding the absence of a recommendation.

(i) Resolutions from Sections. Notwithstanding any deadline established for the introduction of

resolutions to the House of Delegates, the sections authorized in the Constitution shall have the right to adopt resolutions at their meetings immediately preceding the House of Delegates and to have their resolutions introduced at the opening session of the House.

(ii) Resolutions Not Requiring Constitution or Bylaws Changes. Any resolutions not requiring Constitution or Bylaws changes may be submitted by any member of the Medical Association of Georgia through their delegates to the House of Delegates, no less than 48 hours prior to the first session of the House of Delegates.

(iii) Resolution Requiring Constitution and Bylaws Changes. Amendments to these Bylaws or to the Constitution shall be made in accordance with Chapter XIII of these Bylaws.

(c) Majority Needed to Change MAG Policy. In order to be adopted, a policy change must obtain at least 60 percent of the eligible voting members. A proposed policy change receiving more than 50 percent but less than 60 percent shall be referred to the Board of Directors for further policy determination.

CHAPTER VI - BOARD OF DIRECTORS

SECTION 1. PURPOSE AND MEETINGS

(a) General Duties. The Board of Directors shall be the fiduciary and the executive body of the association, and between sessions of the House of Delegates, shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws. The Board of Directors shall provide such headquarters for the Association as may be required to conduct its affairs. The Board of Directors shall by appointment fill any vacancy in office, not otherwise provided for, which may occur during the interval between Annual Sessions of the Association. The appointee shall serve until a successor has been elected and installed. The Board of Directors shall authorize the payment of all necessary expenses incurred by the officers of the Association in the performance of their duties, except those incurred during the Annual Session. The Board of Directors, also, may authorize a special fund to be made available to the President of the Association, who may expend all or any part of it, without restriction, for the good of the Association.

(b) Specific Duties. The Board of Directors shall control and direct all Association publications.

(c) Meetings. The Board of Directors shall meet at the close of the Annual Session to organize. Between the organizational meeting of the Board of Directors and the following Annual Session, the Board of Directors shall meet a minimum of three times, the time and place of such meetings to be determined by the Board of Directors. Special meetings of the Board of Directors may be held on the call of the President, or of the Secretary upon request of eight or more members of the Board of Directors.

SECTION 2. COMPOSITION.

(a) The Board of Directors is composed of: (i) the President, the President-elect, the First Vice President, Second Vice President, the Secretary and the Treasurer; (ii) the Immediate Past President, who shall serve as a full member of the Board of Directors for a period of three years, commencing with the year in which said person becomes the Immediate Past President (such that, at any one time, the Past Presidents from the immediately preceding three years shall be members of the Board of Directors); (iii) the Speaker of the House of Delegates, and the Vice Speaker of the House of Delegates; and (iv) Directors and/or Alternate Directors, who shall be selected in accordance with this Section 2, and (v) Chairman of the Council on Legislation and Chairman of the Georgia Delegation to the AMA, or in his

absence, the Vice Chairman. With the exception of the Chairman of the Georgia Delegation to the AMA, delegates and alternate delegates to the AMA, association members who are past presidents of the AMA, Editor of the Journal, and past presidents other than the three immediate past presidents shall be ex-officio members of the Board of Directors without the right to vote.

(b) Directors and Alternate Directors are selected as follows:

(i) Subject to the provisions of subsequent subparagraphs of this Section, each component county medical society having the requisite number of active members (who are not in arrears in the payment of dues or assessments to the Association) and Life Members, as indicated in the following table, shall be entitled to have the indicated numbers of Directors and Alternate Directors directly representing each such society:

Number of Active and Life Members	Number of Directors and Alternate Directors
100-399	1
400-999	2
1,000-1,499	3
1,500-1,999	4
2,000 or more	5

(ii) If a district society has no component county medical society which has separate representation, then it is entitled to one Director and one Alternate Director to be elected by the members of the district society.

(iii) If a district society has one component county medical society which has separate representation with more than 50 active members who are not members of the component county medical society entitled to separate representation, then the district society is entitled to one Director and one Alternate Director to be elected by all of the members of the district society who are not members of the component county medical society which has separate representation if these members number more than five (5).

(iv) If a district society has one component county medical society entitled to separate representation with less than 50 active members who are not also members of the component county medical society entitled to separate representation, then the component county medical society is entitled to one less Director and one less Alternate Director than the number provided above and the district society is entitled to one Director and one Alternate Director to be elected by all members of the district society including the members of the component county medical society which has separate representation. The Director and Alternate Director elected to represent the district society must be persons not affiliated with the component county medical societies entitled to separate representation. The component county medical society entitled to separate representation shall maintain at least one Director and one Alternate Director.

(v) If a district society has two or more component county medical societies entitled to separate representation with more than 50 active members who are not also members of component county medical societies entitled to separate representation, then the component county medical societies are entitled to the number of Director and Alternate Directors as provided above and the district society is entitled to one Director and one Alternate Director to be elected by the members of the district society who are not also members of any one of the component county medical societies which has separate representation if these members number more than five (5).

(vi) If a district society has two or more component county medical societies entitled to separate representation with less than 50 active members who are not also members of a component county medical society entitled to separate representation, then each component county medical society with the exception of the smallest component county medical society entitled to separate representation shall be entitled to the number of Directors and Alternate Directors provided above. The smallest component county medical society entitled to separate representation is entitled to one less Director and one less Alternate Director than the number provided above and the district society is entitled to one Director and one Alternate Director to be elected by all members of the district society. The Director and Alternate Director elected to represent the district society must be persons not affiliated with the component county medical societies entitled to separate representation. All component county medical societies entitled to separate representation shall maintain at least one Director and one Alternate Director.

(vii) In the event of a membership surge that provides for an increase in representation on the Board of Directors by a component medical society, the component medical society may seat the added representative immediately prior to the election cycle and notification of such election results shall be forwarded to the House of Delegates at the next annual session.

(viii) The Young Physician Section of the Association shall be entitled to a Director and an Alternate Director representative on the Board of Directors, said officers to be elected annually by the members of the Young Physician Section.

(ix) The Medical Student Section of the Association shall be entitled to a Director and an Alternate Director representative on the Board of Directors, said officers to be elected annually by the members of the Medical Student as the Chair and Vice Chair, respectively, of the Medical Student Section.

(x) The Resident Physician and Fellow Section of the Association shall be entitled to a Director and an Alternate Director representative on the Board of Directors, said officers to be elected annually by the members of the Resident Physician and Fellow Section.

(xi) The Organized Medical Staff Section of the Association shall be entitled to eight (8) Directors and eight (8) Alternate Directors on the Board of Directors, said officers to be elected annually by the members of the Organized Medical Staff Section. Those groups from which said directors and alternate directors are chosen must be: (a) group members of MAG, (b) group members of the county medical society (CMS) if a CMS is functioning in their geographic area of the state, and (c) represent diversity in size and geography.

(c) Non Voting Members of the Board of Directors. Alternate Directors shall be members of the Board of Directors without the right to vote except in the absence of the Director from their respective Districts. In the case of a District with multiple Directors, any Alternate from that District may vote in the absence of any Director from the same District. Delegates and Alternate Delegates to the American Medical Association, Association members who are past presidents of the American Medical Association, the Editor of the official publication of the Medical Association of Georgia, Past Presidents other than the three Immediate Past Presidents shall be ex-officio members of the Board of Directors without the right to vote.

SECTION 3. QUORUM. A majority of members of the Board of Directors entitled to vote shall constitute a quorum.

SECTION 4. ELECTIONS AND TERMS OF DIRECTORS.

(a) Terms. The terms of Directors and Alternate Directors shall be three years and shall be staggered in accordance with arrangements approved by the Board of Directors so that as nearly as possible one-third of the Directors and Alternate Directors shall be elected each year. Directors and Alternate Directors serving on the Board of Directors shall be active dues paying members.

(b) Election. In accordance with the provisions of Chapter VI, Section 2(b), district societies and component county medical societies entitled to director representation by one or more directors and alternate directors shall, in appropriate years according to the terms of their respective directors and alternate directors, elect directors and alternate directors prior to the Association's Annual Session and in accordance with the district society's and component county medical society's constitution and bylaws. The Secretary of such societies shall forward to the secretary of the Association, not later than fifteen (15) days before the Annual Session, written notice of the results of such elections. In the absence of timely notice of election of a particular director or alternate director, nominations and elections of such directors or alternate directors shall be made by the members of the House of Delegates at the Annual Session, provided that the persons nominated and elected to such offices shall be members of the society which otherwise would have elected such directors and alternate directors.

(c) Vacancies. If a director dies, resigns, or is unable, either temporarily or permanently, to fill effectively the office of director as determined by the Judicial Council and confirmed by a four-fifths vote of those voting members of the Board of Directors present at the Board's subsequent meeting, he shall be succeeded in such office until the next Annual Session by the alternate director of the district society or the component county medical society which he represents, or until the Judicial Council determines that he or she is once more able to effectively fill the office of director. If an alternate director dies, resigns or is unable to fill effectively the office of alternate director, or is serving as director pursuant to the provisions of the immediately preceding sentence of this section, until the next Annual Session, the person to fill the vacancy so created shall be elected from among qualified members of the district society or the component county medical society which the Alternate Director whose office is being filled represented. In lieu of the foregoing provision, the district medical society or the component county medical society may elect at its discretion, a successor or successors from among the qualified members of the district or component county medical society. Both the new director and alternate director shall only serve until the next Annual Session at which time notice of election from the district society or the component county medical society will be presented to fill out the balance of the terms for which the original director or alternate Director was elected. Such interim notices of election shall be forwarded in like manner as regular notices of election for director and alternate director. In the absence of such timely notices of election, such interim elections for the balance of such terms shall be filled by the members of the House of Delegates at the Annual Session.

(d) Duties of Directors and Alternate Directors. Each director shall be organizer, and peacemaker for the district represented by the respective director. The director shall visit each county in the respective district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the conditions of the profession, and to keep in touch with the activities of, and to aid in the betterment of the component societies in that district. The director shall submit an annual report at the Annual Session of the House of Delegates, listing membership data of each component society within the respective district and describing the work and the condition of the profession of each county in that district. The alternate director shall assist the director in the performance of duties.

SECTION 5. ORGANIZATION OF BOARD.

(a) Officers

(i) Chairman & Vice Chairman. A Chairman and a Vice-Chairman of the Board of Directors shall be elected annually by the Board of Directors and shall be chosen from among the Directors. Their election shall take place at the organizational meeting of the Board of Directors immediately following the annual session of the House of Delegates. They shall serve for one year but may not serve more than three terms. The Chairman or, in his absence, the Vice-Chairman, shall preside over meetings of the Board of Directors and shall appoint all necessary committees of the Board of Directors.

(ii) Secretary. The Secretary of the Association shall serve as Secretary of the Board of Directors, or, at the Secretary's request, the Board of Directors may designate the Executive Director to serve in this capacity.

(b) Executive Committee. The Board of Directors shall have an Executive Committee as provided for in Chapter VII of these Bylaws.

SECTION 6. PROCEDURES. The deliberations of the Board shall be conducted in accordance with the current edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure unless contrary to the Association's Constitution and Bylaws or procedures of the House of Delegates.

CHAPTER VII - EXECUTIVE COMMITTEE

SECTION 1. PURPOSE AND MEETINGS. The purpose of the Executive Committee is to be the fiduciary of the House of Delegates and the Board of Directors in between meetings of the Board of Directors and House of Delegates.

(a) Duties. The Executive Committee shall: (1) make recommendations to the Board of Directors; (2) carry out such items of business as are referred to it; (3) appoint all Association committees, including chairmen; (4) nominate members of all boards required by the law of the State of Georgia all such recommendations being subject to confirmation by the Board of Directors; (5) have the authority and power of the Board of Directors between meetings of the Board of Directors; (6) be empowered to select an executive director who shall be responsible to the Executive Committee for the operations of the headquarters office, subject to the approval of the Board of Directors; (7) direct the Executive Director in carrying out the mandates and policies of the Board of Directors and the House of Delegates; (8) develop and evaluate the strategic directions of the Association on an annual basis, including a meeting during the first half of the MAG fiscal year with committee chairs to gather input, make recommendations to the Board of Directors as appropriate, and submit an annual report to the House of Delegates; (9) determine the terms of employment and salary of the Executive Director. The Compensation Subcommittee shall recommend compensation to the Executive Committee after a review of the performance of the Executive Director. Such review will be based upon the job description and objectives performance criteria developed by the Compensation Subcommittee; and (10) except as otherwise provided in these Constitution and Bylaws, provide oversight of all MAG communications, whether printed, electronic or otherwise.

(b) Meetings. The Executive Committee shall meet as frequently as necessary to conduct Association business between meetings of the Board of Directors. The Executive Committee may meet by teleconference, provided that adequate notice is given and a quorum is met.

SECTION 2. COMPOSITION. The Executive Committee is a committee of the Board of Directors. The Executive Committee shall be composed of the President, the President-Elect, The Immediate Past President, the First Vice President, the Second Vice President, the Secretary, the Treasurer, the Chairman of the Board of Directors, the Vice Chairman of the Board of Directors, the Speaker of the House of

Delegates and the Vice Speaker of the House of Delegates, the Chairman of the Georgia Delegation to the American Medical Association House of Delegates, or in his absence, the Vice Chairman, and the Chairman of the Council on Legislation. The President shall serve as the Chairman of the Executive Committee, and the President-Elect shall serve as the Vice-Chairman of the Executive Committee. In the event that neither the President nor the President-Elect can preside over an Executive Committee meeting, the meeting shall be chaired by the next available officer in the following order: Speaker of the House of Delegates, Chairman of the Board of Directors, First Vice President, Second Vice President, Vice Chairman of the Board of Directors, Vice Speaker of the House of Delegates. The Executive Committee shall have a Compensation Subcommittee which shall be chaired by the MAG President, and shall be composed of the President, President-Elect, Immediate Past President, Speaker of the House of Delegates, Treasurer, and Chairman of the Board.

SECTION 3. QUORUM. At any duly called meeting of this Committee for which proper notice has been given, any six (6) members of the Committee shall constitute a quorum.

SECTION 4. ORGANIZATION

(a) President. The President shall (1) preside at all general meetings of the Association; (2) report to a general session of the Annual Session; (3) assist the Directors in improving the county and district societies as far as practicable; (4) serve as a member of the Board of Directors and as Chairman of the Executive Committee; (5) serve as a member of all committees of the Association with the authority to call a meeting of any committee when necessity demands it or after failure of the Chairman to do so. With the approval of the Board of Directors, the President may terminate any committee whose function has been fulfilled or replace any member of any committee who fails to show interest in performing the duties assigned; and (6) serve as an ex-officio member of the House of Delegates without the right to vote. The President, with the authorization of the Executive Committee, Board of Directors or House of Delegates, shall have the right to contract on behalf of the Association.

(b) President Elect. The President Elect shall be a member of the Board of Directors, shall serve as the Vice-Chairman of its Executive Committee, and shall be a member, ex-officio without the right to vote, of all standing committees. In order to become familiar with all the activities of the Association, it shall be the duty of the President Elect to attend all meetings of the Board of Directors and, when possible, the standing committees. The President Elect shall be an ex-officio member of the House of Delegates without the right to vote.

(c) Immediate Past President. The Immediate Past President shall serve as Immediate Past President for a term of one-year following the term of office as President and as such shall serve on the Board of Directors and its Executive Committee. The following two years the Immediate Past President shall continue to serve as a member of the Board of Directors.

(d) The Vice Presidents. The First Vice President and the Second Vice President shall be members of the Board of Directors. The Vice Presidents shall assist the President in the discharge of duties. The Vice Presidents shall be members of the Executive Committee, and shall attend all meetings. Upon request or in the absence of the President, the Vice-Presidents will preside over the general meetings of the Association in rotation with the exception of Executive Committee meetings. The Vice Presidents shall be ex-officio members of the House of Delegates without the right to vote.

(e) Secretary.

(i) The Secretary and the Executive Director shall attend the general meetings of the Association and the meetings of the House of Delegates. The Secretary will keep the minutes of their

respective proceedings. The Secretary shall be Secretary of the Board of Directors and its Executive Committee. The Secretary shall be an ex-officio member, without the right to vote, of the House of Delegates and all committees of the Association.

(ii) The Secretary, under the direction of the Executive Committee of the Board of Directors, shall be custodian of all Association record books and papers, conduct the official correspondence of the Association, maintain membership records, and provide for the registration of members at Annual Sessions. The Secretary shall collect the regular per capita assessment from the Association's members or the component societies in accordance with the provisions of Chapter X, Section 1 of these Bylaws, and shall make all required reports to the American Medical Association.

(f) Treasurer. Except as otherwise provided in these Bylaws, the Treasurer shall receive all funds of the Association together with bequests and donations. The Treasurer shall pay money out of the treasury only on authorization of the Board of Directors and shall furnish the audited financial statements to the Board of Directors at its last meeting of the calendar year. The fiscal year includes the period of time from January 1 to December 31 inclusive. A financial report shall be published in the official publication of MAG as soon as practicable after the end of each fiscal year. All checks for Association expenditures shall be signed by the Treasurer, Executive Director or his designee. Not less than quarterly, the Treasurer shall review all checks written in excess of $5,000.00. The Treasurer shall serve as the Chairman of the Committee on Finance.

The Treasurer shall be an officer of the Association and a voting member of the Board of Directors and of the Executive Committee of the Board of Directors. The Treasurer shall serve as Chairman of the Committee on Finance. The Treasurer shall be an ex-officio member without the right to vote of the House of Delegates. The Treasurer shall give bond in such sum as may be fixed by the Board of Directors, the premium on such bond to be paid by the Association. No person shall serve contemporaneously as both the Treasurer and the Secretary of the Association.

(g) Speaker of the House of Delegates. (See Chapter V, Section 5, Organization (a), Speaker of the House of Delegates and Vice Speaker of the House of Delegates.)

(h) Vice Speaker of the House of Delegates. (See Chapter V, Section 5, Organization (a), Speaker of the House of Delegates and Vice Speaker of the House of Delegates.)

SECTION 5. PROCEDURE. The deliberations of the Executive Committee shall be conducted in accordance with the most current edition of the American Institute of Parliamentarians Standard Code of Parliamentary Procedure unless contrary to the Association’s Constitution and Bylaws.

CHAPTER VIII -- ELECTION AND TERMS OF OFFICERS

SECTION 1. CRITERIA

(a) Officers must have been an active member of the Medical Association of Georgia for two years immediately prior to election. The Speaker and Vice Speaker of the House of Delegates shall be elected from among the members of the House of Delegates.

(b) An individual running for an office elected by a given constituency must divest himself or herself of any other office within the same organization that would be left vacant if he or she were successful in his or her candidacy for the new office. Such an individual must agree, at the time of announcing for candidacy, to resign from the currently held position at the earliest time at which another

individual may fill the seat in a duly held regular election by the constituency, and regardless of the outcome of the election.

SECTION 2. PROCEDURE

(a) Procedure for nominations and election of officers. Nominations for President-Elect, Second Vice-President, Secretary, Treasurer, Delegates and Alternate Delegates to the American Medical Association, Speaker and Vice-Speaker of the House of Delegates in years when the predecessors' term of office are expiring, as well as of Directors and Alternate Directors with respect to whom notice of election has not been forwarded by the Secretary of the electing society to the Secretary of the Association not later than fifteen (15) days before the Annual Session and as required in Chapter VI, Section 4 of these Bylaws, shall be made by members of the House of Delegates orally from the floor at the first meeting thereof occurring in the Annual Session and no nominating or seconding speech shall exceed two minutes.

(b) The officers of the Association, with the exception of the Directors and Alternate Directors, shall be elected during the annual session. Elections of such officers shall be made by the official voting members of the House of Delegates. Such election shall occur as provided in the House of Delegates' order of business at either session of the House of Delegates of the Annual Session. When the Executive Committee schedules the House of Delegates meeting, the Executive Committee shall indicate at which session the election will be conducted. Election of Directors and Alternate Directors shall occur in accordance with Chapter VI, Section 4 of these Bylaws.

(c) Terms of Office

(i) President. The President shall be elected annually and shall become President upon installation at the inaugural ceremony at the Annual Session, serving thereafter as President until the installation of a successor. The inauguration of the President may be held at any time during the Annual Session.

(ii) President Elect. The President Elect shall be elected annually and shall become President at the time of the next Annual Session. If the President-elect shall be unable to serve, both a President and President-elect shall be elected at the appropriate annual session.

(iii) First Vice President. The First Vice President shall serve for one year.

(iv) Second Vice President. The Second Vice President shall be elected annually and shall become First Vice President at the time of the next Annual Session.

(v) Speaker and Vice Speaker. The Speaker of the House of Delegates and the Vice Speaker of the House of Delegates shall be elected from among the members of the House of Delegates and shall serve for terms of two years, provided each shall remain a duly elected delegate. No member shall hold the office of Speaker and Vice Speaker more than three consecutive terms.

(vi) Secretary. The Secretary shall serve a term of two years. No member shall hold the office of Secretary more than three consecutive terms.

(vii) Treasurer. The Treasurer shall serve a term of two years. No member shall hold the office of Treasurer more than three consecutive terms.

(d) Delegates and Alternate Delegates to the AMA. Delegates and Alternate Delegates to the

American Medical Association shall be elected in accordance with the Constitution and Bylaws of the American Medical Association and shall be elected in accordance with the provisions of these Bylaws consistent therewith and the policies and procedures of the AMA delegation consistent therewith.

(e) If the President dies, resigns, becomes incapacitated or is removed from office, the President-elect shall immediately become President and shall serve for the remainder of the unexpired term and for the next full year thereafter. If the President-elect is unable to serve, then the Speaker of the House of Delegates shall fill the office for the remainder of the unexpired term.

In the event a catastrophic occurrence shall exhaust the aforementioned line of succession to the Presidency, the Vice Speaker of the House of Delegates shall be authorized to convene an emergency meeting of the House of Delegates for the purpose of naming an Acting President to serve until the next annual session. The Acting President, so named, shall have the powers and duties of the President during the term for which the Acting President is elected to serve. Should the Vice Speaker be unable to act, then five directors or any 10 delegates shall be authorized to convene the House of Delegates in emergency meeting.

(f) Vacancies.

(i) An officer of the Association may voluntarily resign his or her office, either permanently or temporarily, upon his or her incapacity to serve by serving notice to the Chairman of the Board of Directors, and the Executive Director. Upon such resignation or temporary withdrawal from office, the officer shall be succeeded as set out in these Bylaws. If no provision is made in these Bylaws for the succession of such officer, the President may nominate, and the Board of Directors, by simple majority vote of those present, may select a replacement to serve until the next regular election or until the original officer resumes his or her office.

(ii) An officer of the Association may be removed from office, either permanently or temporarily, on the recommendation of the Judicial Council, confirmed by a simple majority vote of those present at the subsequent meeting of the Board of Directors. Specific notice to the Board of Directors as to the subject of removal to be addressed at a meeting must be issued as part of the meeting notice. Upon such removal, the officer shall be succeeded as set out in these Bylaws. If no provision is made in these Bylaws for the succession of such officer, the President may nominate, and the Board of Directors, by simple majority vote of those present, may select a replacement to serve until the next regular election.

CHAPTER IX - COMMITTEES

SECTION 1. STANDING COMMITTEES. The standing committees of the Association shall be as follows:

(A) Executive Committee of the Board of Directors
(B) Committee on Finance
(C) Judicial Council
(D) Committee on Constitution and Bylaws
(E) Committee on Annual Session
(F) Council on Legislation

(a) Committee on Finance

(i) Charge. The Committee on Finance shall cause to be audited all accounts of the Association.

The Committee may designate a time that all committees shall submit their budgets for the following fiscal year. The Committee shall propose an annual budget for the fiscal year beginning January 1, and running through December 31. Such budget shall be subject to modification and approval of the Board of Directors.

(ii) Membership. The Chairman of the Board of Directors shall appoint from among its members a committee of at least seven members to be known as the Committee on Finance. The Treasurer shall serve as Chairman of the Committee on Finance.

(b) Committee on Constitution and Bylaws. The Committee on Constitution and Bylaws shall be responsible for the continuing study of the organization of the Medical Association of Georgia. It shall recommend to the House of Delegates and the Board of Directors, any amendments or revisions which seem necessary or advisable. At least every five years the Committee on Constitution and Bylaws shall recommend revisions after a complete study of the organization of the Association and its Constitution and Bylaws. Proposed amendments shall be referred to the Committee on Constitution and Bylaws for recommendation before action thereon is taken by the House of Delegates.

(c) Committee on Annual Session. The Committee on Annual Session shall carry out the approved policies of the Association as they relate to the annual meeting as directed by the Board of Directors. It shall study and make recommendations concerning the Annual Session of the Association.

(d) Council on Legislation. The Council on Legislation shall continually review pending legislation, active bills, the need for particular legislation, recommend positions of policy to policy-making bodies of MAG and communicate the Medical Association of Georgia's position to the Georgia Congressional delegation and to State legislators.

(e) Judicial Council

(1) Charge. The functions of the Judicial Council shall be:

(a) To serve as the judicial authority of the Association. The decision of the Judicial Council shall be final, except as set forth in Chapter VI, Section 4, paragraph (c) and Chapter VII, Section 4, paragraph (g) (ii) of these Bylaws.

(b) To have original jurisdiction with respect to: (i) all questions involving membership as provided in Chapter II of the Bylaws; (ii) all controversies arising under the Association's Constitution and Bylaws and under the Principles of Medical Ethics to which the Medical Association of Georgia is a party; (iii) all controversies between two or more component societies or their members; (iv) the establishment of principles and interpretation of medical ethics; (v) the interpretation of the Constitution and Bylaws and policies of the Association; (vi) referrals from component county medical societies when such societies request that the Association assume original jurisdiction of the matter in behalf of such county societies, provided that the Judicial Council approves acceptance of original jurisdiction of such matters; (vii) direct appeals by complainants when the component county medical societies having original jurisdiction have not commenced investigation within thirty (30) days after receipt of a complaint; and (viii) interpretation and final judgment on all matters pertaining to the MAG Statement of Conflicts of Interest.

(c) To have appellate jurisdiction in questions of law and procedure but not of fact in all cases which arise within the Medical Association of Georgia and two or more of its component societies, between a member or members and the component society to which said member or members belong or between members of different component societies of the Association. Notice of appeal shall be filed

with the Judicial Council within thirty (30) days of the date of the disputed decision and the appeal shall be perfected within sixty (60) days thereof; provided however, that the Judicial Council, for what it considers good and sufficient cause may grant an additional thirty (30) days for perfecting the appeal.

(d) To receive appeals filed by applicants who allege that they, because of color, creed, race, religion, ethnic origin, national origin, or sex, have been unfairly denied membership in a component and/or constituent association, to determine the facts in the case, and to report the findings to the House of Delegates. If the Council determines that the allegations are indeed true, it shall admonish, censure, or, in the event of repeated violations, recommend to the House of Delegates that the component society involved be declared to be no longer a constituent member of the Medical Association of Georgia.

(e) To investigate general ethical conditions and all matters pertaining to the relations of physicians to one another or to the public, and make recommendations to the House of Delegates.

(f) To request the President to appoint investigating juries to which it may refer complaints or evidence of unethical conduct which in its judgment are of greater than local concern. Such investigating juries, if probable cause for action be shown, shall submit formal charges to the President, who shall appoint a prosecutor to prosecute such charges against the accused before the Judicial Council in the name and on behalf of the Medical Association of Georgia. The Council may acquit, admonish, suspend or expel the accused.

(g) To approve applications and nominate candidates for affiliate membership as otherwise provided for in these Bylaws.

(h) To investigate any request from any Delegate or component medical society for an officer's removal from office and to forward its recommendation pertaining to such a request to the Board of Directors for the Board's final decision.

(2) Membership. The Judicial Council shall consist of five active members. The members of the Council shall be elected by the House of Delegates on nomination by the President. No member, while serving on the Judicial Council, shall be a general officer of the Association, or hold any other elected or appointed position whatsoever in the Association. A member of the Judicial Council shall, however, be permitted to serve as a delegate or alternate delegate to the Medical Association of Georgia’s House of Delegates, and as a delegate, alternate delegate, or general officer of the American Medical Association.

(3) Terms of Service. Members of the Judicial Council shall be elected by the House of Delegates for terms of five years, so arranged that, at each Annual Session of the House of Delegates, the term of one member expires.

(4) Tenure. Members of the Judicial Council shall serve for no more than two terms, but a member elected to serve an unexpired term shall not be regarded as having served a term unless a term of three or more years has been served.

(5) Vacancies. Any vacancy occurring on the Judicial Council shall be filled at the next meeting of the House of Delegates. The new members shall be elected by the House of Delegates, on nomination by the President, for the remainder of the unexpired term.

(6) Rules and Regulations. The Judicial Council shall select a chairperson and vice chairperson, and it may adopt such rules and regulations, as it deems necessary and appropriate for the conduct of its affairs. These rules and regulations shall be in conformity with the Constitution and Bylaws of the Medical Association of Georgia.

SECTION 2. SPECIAL COMMITTEES. Special committees as required for the conduct of the business of the Association shall be instituted by the Executive Committee, and members thereof appointed only in the event that existing committees are not qualified or able to address a specific issue. All special committee appointments shall be made on an annual basis. Reports of committees requiring action by the House of Delegates shall be submitted prior to the Annual Session to assist in the coordination of all committee activities. Recommendations requiring action prior to the House of Delegates shall be submitted to the Executive Committee or the Board of Directors.

(a) Sunset. Each special committee shall be established for a period of one year from inception, after which time it will cease to exist unless re-established by action of the Executive Committee. The appointing authority shall conduct reviews of the committees, according to a regular schedule, in order to ascertain the need for their re-establishment.

SECTION 3. APPOINTMENTS AND TERMS OF COMMITTEE MEMBERS. All standing committee members will be recommended by the Executive Committee unless otherwise specified in the Bylaws. Standing committee members will be appointed for terms of 2 years and may not serve more than three terms, unless directed by specific action of the Executive Committee, or as otherwise specified by these Bylaws. Committee chairmen will not be subject to term limits, except the Council on Legislation chair, who shall be elected annually for no more than eight (8) consecutive years.

(a) Vacancies. If any committee member is unable, for any reason, to complete the term of service on a committee, a replacement shall be appointed for the remainder of the member's term, unless otherwise specified in the Bylaws. Replacements may be recommended by the committee chairmen and shall be appointed by the MAG President for the remainder of the un-expired term of office, unless otherwise provided in the Bylaws.

SECTION 4. REPORTS. All MAG committees have a continuing duty to provide information and submit reports to the Chairman of the Board of Directors, on matters relating to the areas of responsibility assigned to them under the provisions of these Bylaws.

CHAPTER X - FUNDS AND EXPENDITURES

SECTION 1. DUES AND ASSESSMENTS. The annual dues and assessments shall be established by the House of Delegates upon recommendation of the Board of Directors and shall be levied per capita on the active members of the Association. They shall be payable on or before the commencement of the fiscal year for which they are established by the House of Delegates and in accordance with the next fiscal year's budget, unless a different due date is specified in the resolution adopted by the House of Delegates. Dues shall be paid in concert with the following procedures:

(a) All active members of the Association who are also members of component societies shall pay such dues and assessments in accordance with the following procedures: The secretary of each component society shall certify each year, on the date specified by the Secretary of the Association, its correct mailing addresses, and the amount of dues and assessments for the next fiscal year to be levied on its members pursuant to the constitution and bylaws of the component county society. The Secretary of the Association shall bill and collect from such members for dues and assessments due the Association and at the request of the secretary of any component society the dues and assessments due the particular component society. Within 60 days of receipt of such dues or assessments, the Secretary of the Association shall remit to the secretary of the particular component society all component society dues and assessments collected by such date from its members.

(b) Any physician qualified for membership under the provisions of Chapter II of these Bylaws as a Direct Member shall be billed by the Secretary of the Association for dues and assessments due to the Association set by the House of Delegates. The Secretary shall collect all such dues and assessments.

(c) Any member whose dues and assessments to the Association have not been paid for the annual membership dues year on or before thirty days after the commencement of that fiscal year shall stand suspended. Such members may be automatically reinstated provided all dues and assessments are paid no later than the end of that fiscal year. An active member who fails to pay dues and assessments for two or more consecutive years may be reinstated upon reapplication and payment of the current year's dues and assessments plus the payment of any mandatory assessment levied during his or her last year of membership.

(d) Any physician transferring to the Medical Association of Georgia from another state medical association shall be excused from paying current dues and assessments provided all dues and assessments to the state association from which the physician transferred have been paid. The record of payment of dues and assessments on file in the office of the Association shall be final as to the fact of payment by a member and as to that member's right to participate in the business and proceedings of the Association and of the House of Delegates.

(e) Any county society which fails to make the required report before the Annual Session of the Association shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Association or of the House of Delegates.

CHAPTER XI - EXECUTIVE DIRECTOR

The Executive Director shall be the administrative agent of the Association, of its Board of Directors, and of all its committees. The Executive Director shall be the executive agent of the Association transacting its business under the direction of the Executive Committee of the Board of Directors and shall be the directing manager of the headquarters office. When authorized by the Executive Committee, the Board of Directors, and/or the House of Delegates, the Executive Director shall have the right to contract on behalf of the Association. The Executive Director shall discharge the administrative functions of the Association not within the duties of the officers of the Association or its committees. The Executive Director shall keep the Association informed in regards to these non-professional matters affecting the medical profession. The Executive Director shall be responsible to the Executive Committee of the Board of Directors for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks assigned by the Committees, the Board of Directors, the Officers of the Association, and/or, the House of Delegates.

The Executive Director shall be responsible to the Executive Committee of the Board of Directors and the Executive Director shall prepare a report on the activity and status of the headquarters office for the Executive Committee of the Board of Directors at each of their meetings to keep the Committee informed at all times.

CHAPTER XII - OFFICIAL PUBLICATION.

SECTION 1. OFFICIAL PUBLICATION. The Journal shall be the official publication of the Association.

SECTION 2. JOURNAL. The Board of Directors shall appoint an editor of the Journal and define the powers and duties of the Editor and Editorial Board, and shall appoint an Editorial Board annually. The Executive Committee shall provide oversight for the Journal of the Medical Association of Georgia.

SECTION 3. PUBLICATION OF PAPERS AND RECORD. All papers presented before the Annual Session shall be submitted to the Editor for consideration for publication in the Journal. Abstracts of transactions of the House of Delegates shall be published as early as practicable. Records and notices of component county and district society meetings may also be published, and consideration given to the publication of papers presented before such meetings.

CHAPTER XIII - AMENDMENTS

These Bylaws may be amended at any Annual Session by a majority vote of the House of Delegates provided an amendment shall be acted on not sooner than the day following that on which it was introduced.

Amendments to these Bylaws or to the Constitution may be proposed by action of the House of Delegates, or by the Board of Directors, or the Executive Committee of the Board of Directors, or by the Committee on Constitution and Bylaws, or by any group of active members numbering five or more. Proposed amendments must be submitted to and received by the Constitution and Bylaws Committee not less than forty-five (45) days prior to the Annual Session at which they are to be acted upon. In an emergency situation and upon the affirmative vote of two-thirds of the Board of Directors, a meeting of the Constitution and Bylaws Committee shall be called to consider additional amendments to the Constitution and Bylaws following the expiration of the normal amendment introduction period ending forty-five (45) days prior to the Annual Session.

CHAPTER XIV - REPEALER

On the adoption of this Constitution and these Bylaws, all rules and regulations in conflict herewith are hereby repealed, provided that all officers, delegates, and committee persons now in office shall continue their incumbency until their successors are duly elected and installed or chosen as herein provided.

MAG Policy Compendium

5
Abortion

5.999 Abortion
HD 4/1/1983
Abortions should be performed by a properly qualified Doctor of Medicine. The procedure should take place in a hospital or clinic that has personnel and facilities which will provide adequate protection against infection, and proper equipment to combat blood loss, shock or respiratory distress. Physicians must have the right to refuse to perform abortions for any reason. (Reaffirmed 10/2009; 10/2014; 10/20/2019)

15
Accident Prevention: Motor Vehicles

15.987 Vehicle Injury Prevention
HD 10/17/2010
MAG supports the sale and use of helmets and protective gear for recreational ATVs, and supports the industry in developing technology to improve safety. (Resolution 104A.10) (Reaffirmed 10/17/2015)

15.988 Cell Phone Use
HD 10/13/2007
MAG supports legislation that prohibits the use of a cell phone while operating a vehicle for drivers 18 years old and younger and allow only hands free use by drivers over 18 years old. (Res.318C.07) (Reaffirmed 10/20/2012; 10/21/2017)

15.989 Seat Belts
HD 8/22/2003
MAG believes children ages 4 to 8, or children weighing 40 to 80 pounds, be required to use a booster seat and proper seat belts.(Resolves 1-4, Res. 300C-03) (Reaffirmed 10/5/2008; 10/20/13; 10/20/18)

15.990 Seat Belts
HD 8/22/2003
MAG supports requiring individuals riding in the back seat of a vehicle and all individuals in a pickup to use proper seat belts. (Resolves 1-4, Res. 301C-03) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

15.991 Child Restraints
HD 10/16/2010
MAG strongly supports the use of child restraint devices in automobiles and the irrefutable scientific evidence concerning the efficacy of such devices. (Special Report 04.10, III) (Reaffirmed 10/17/2015)

15.992 Driving Under the Influence (DUI)

HD 5/1/2000

MAG supports establishing the legal drinking age for purchase of alcoholic beverages at age 21. MAG supports the elimination of the nolo contender pleas for the first offense for drunken driving, and the mandatory suspension of a driver's license for the third offense in a five-year period, with a provision for a one-year mandatory DUI driving course to be financed through additional taxes on alcoholic beverages. (Comm: 10-00) (Reaffirmed 10/2005; 10/16/10; 10/17/2015)

15.993 Seat Belt Law

HD 5/1/1995

MAG supports supplementing the mandatory seat belt fines with educational and/or community service requirements to further deter violations of the mandatory seat belt law. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

15.994 Failed Blood Alcohol Test

EC 2/1/1994

MAG supports "on the spot" confiscation of the driver's license of anyone under the age of 21 who fails a blood alcohol test or who refuses to take such a test. (Reaffirmed 05/2000; 10/5/2008, 10/20/2013; 10/20/2018)

15.995 Driving Under the Influence Prevention Support

HD 4/1/1993

MAG supports efforts to prevent individuals from driving while under the influence of mind-altering substances. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

15.997 Student Driver Education

HD 4/1/1991

MAG supports a comprehensive, model driver's education program through the public school system available to all students. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

15.998 Driving under the influence and Blood Alcohol Level

BD 1/1/1991

MAG encourages local county medical societies to work in their communities to address the problems of impaired driving, including the possible lowering of legal blood alcohol levels. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

20
Acquired Immunodeficiency Syndrome (AIDS)

20.991 Public Health Efforts to Prevent AIDS

HD 10/17/2009

MAG urges members to continue to seek information on AIDS relevant to their daily practice to enhance the success of public health efforts to prevent AIDS. When considering the potentially nfectious nature of diseases such as HIV and Hepatitis B physicians should consider current evidence and act prudently with the patients' best interest in mind. (Special Report, Appendix III; reaffirmed 10/2014; 2019)

20.995 Compassion in AIDS Treatment
HD 4/1/1991
Every physician treating and caring for AIDS patients should remember compassion and professionalism in their treatment and care of patients with AIDS. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

20.999 Dignity of the Patient
HD 4/1/1988
MAG supports the dignity and self respect of all medical patients, and opposes all forms of prejudice against any medical patient. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/19)

30
Alcohol and Alcoholism

30.996 Alcohol Treatment Centers and the Disable Doctors Program
HD 10/17/2009
MAG supports the creation of sufficient alcoholic treatment centers to meet the need in Georgia. It believes that alcoholics should be taken to such centers and given proper medical treatment instead of being arrested and taken to jail for public drunkenness. Although Georgia no longer has a drug treatment program specifically for physicians, we support the concept and encourage the Georgia medical licensing board to establish one. This has been successfully done in other states. (Special Report: Appendix III; reaffirmed 10/2014; 10/20/2019)

30.997 Advertising Beer Products
EC 5/1/1992
MAG supports eliminating beer advertising on television. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

30.998 Alcohol Awareness Information
HD 4/1/1988
MAG recognizes the detrimental effects of alcohol advertising on the public and supports the use of warning labels on alcohol products and in ads. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

35
Allied Health Professionals

35.970 Physical Therapists -Direct Access
HD 10/21/2018
MAG opposes any expansion of current law limiting patients direct access to a physical therapist. (Special Report 03.18, III)

35.971 Doctor of Medical Science
HD 10/22/2017
MAG does not recognize any non-physician medical degree including “Doctor of Medical Science” as adequate training and education for the purpose of scope of practice expansion and/or independent

practice of medicine. (Res. 108A.17)

35.972 Optometric Scope of Practice

HD 10/20/2013
MAG opposes any optometric scope of practice expansion. (Officer 01.13, Rec. 12; Reaffirmed 10/20/2018)

35.973 Marriage and Family Therapists -- scope

HD 10/20/2013
MAG opposes allowing marriage and family therapists to diagnose patients. (Officer 01.13, Rec. 11; Reaffirmed 10/20/2018)

35.975 Chiropractors -- diagnose patients

HD 10/20/2013
MAG opposes allowing chiropractors to diagnose patients. (Officer 01.13, Rec. 8; Reaffirmed 10/20/2018)

35.976 Chiropractors -- school physicals

HD 10/20/2013
MAG opposes allowing chiropractors to perform school physicals. (Officer 01.13, Rec. 9; Reaffirmed 10/20/2018)

35.977 Biosimilar Substitutions -- Pharmacists

HD 10/20/2013
MAG supports pharmacists obtaining a physician's "consent" prior to substituting a biosimilar for a biologic. (Officer 01.13. Rec. 7; Reaffirmed 10/20/2018)

35.978 Therapeutic Drug Substitution -- Pharmacists

HD 10/20/2013
MAG opposes proposals that would allow a pharmacist the ability to substitute therapeutic drugs. (Officer 01.13, Rec. 6; Reaffirmed 10/20/2018)

35.979 Pharmacists Prescribing

HD 10/20/2013
MAG supports current law that allow a pharmacist to administer an adult vaccine with a patient- specific prescription; MAG opposes pharmacists administering all adult vaccines under a blanket protocol agreement with a physician; MAG supports the equitable distribution of vaccines among physicians, hospitals, and county health departments. (Officer 01.13, Rec. 5; Reaffirmed 10/20/2018)

35.980 Chiropractic Spinal Manipulation

BD 4/18/2009
MAG opposes the use of chiropractic spinal manipulation with anesthesia, and continues to educate MAG members of MAG's concerns regarding such practices. (Reaffirmed 10/2014; 10/20/2019)

35.982 Medical Assistants

HD 10/13/2007
MAG believes that the level of supervision in needed patient care should be based on the medical judgment of the physician responsible for the care. (Resolution 216B.07) (Reaffirmed 10/20/2012;

10/21/2017)

35.983 Disease Screening by Non-physicians

HD 5/4/2002

MAG opposes pharmacists or other non-physicians offering screening for specific disease states without specific physician involvement in, or supervision of, such screening. (Res: 107AB-07 (Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

35.984 Scope of Practice

HD 5/19/2001

MAG, in the public interest, opposes enactment of legislation to authorize the independent practice of medicine by any individual who has not completed the state's requirements for licensure to engage in the practice of medicine and surgery in all of its branches. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016; 10/22/2017)

35.985 Physical Therapy

HD 5/1/2000

MAG opposes allowing physical therapists to practice without the benefit of a physician's examination of the patient and referral to the physical therapist for therapy. (Comm: 10-00,Appendix B) (Reaffirmed 10/2005) (Reaffirmed 10/16/2010; 10/17/2015)

35.986 Physician Assistants

HD 10/16/2010

The designation of physician assistants should be limited to those persons who have satisfactorily ompleted training and an examination approved by the Georgia Composite Medical Board. MAG encourages physicians to be familiar with and comply with the supervision requirements as set forth in the Georgia Code, and rules and regulations. The Georgia Composite Medical Board should continue to ensure that the utilization of physician assistants does not lead to abuses in medical care which might be harmful to patients. MAG opposes independent licensure for physician assistants because it would confuse the public and pervert the concept of the PA as an assistant to the physician. (Special Report 04.10 III) (Reaffirmed 10/17/2015; 10/22/2017)

35.987 Midwives

HD 5/1/2000

MAG believes that lay midwifery should be prohibited and that Certified Nurse Midwives or licensed physicians are the proper professionals to provide the delivery of prenatal services. (Comm:10-00, Appendix B) (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

35.988 Blood Test Authorization

HD 10/16/2010

MAG opposes pharmacists having the legal authority to perform capillary blood tests. Special Report 04.10, III (Reaffirmed 10/17/2015)

35.990 Physician Assistant DEA Number

EC 1/1/1998

MAG opposes independent DEA numbers for physician assistants. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

35.994 Psychologists' Hospital Admitting Privileges
BD 1/1/1996
MAG opposes psychologists having hospital admitting privileges. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

35.996 Midwives
HD 4/1/1993
MAG opposes state certification of lay midwives. (Reaffirmed 5/2000, 10/5/2008; 10/20/2013; 10/20/2018)

35.997 Chiropractors - Lab Tests
HD 4/1/1991
MAG opposes granting chiropractors the authority to order lab tests. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

35.998 Delegation of Medical Acts
BD 9/1/1983
MAG affirms the authority of physicians to delegate medical acts to non-licensed individuals for which the physician is both responsible and liable. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

55
Cancer

55.990 Lung Cancer Screening Facilities
HD 10/20/2019
MAG shall encourage all commercial payers to: 1) encourage their provider networks to refer to only those screening programs that practice the Quality Triad of Lung Screening, and 2) avoid the practice of steering patients to CT scan facilities that are not CMS-accredited and which do not provide patient navigation. (Res. 115A.19, resolve 3).

55.991 Quality LDCT Lung Cancer Screening
HD 10/20/2019
MAG supports centers offering LDCT lung cancer screening programs that utilize the Quality Triad of Safe Lung Screening: 1) navigation with prompt communication, 2) recognition by the CMS-approved Accrediting Organization, and 3) provide a virtual and/or on site multi-disciplinary team to manage findings...(Res. 115A.19. resolve 2)

55.992 Screening
HD 10/20/2019
MAG endorses, and encourages its component county medical societies to endorse, lung cancer screening by low-dose CT as the primary means by which to detect early stage lung cancer and contributes to reducing the mortality of lung cancer in Georgia. (Res. 115A.19, resolve 1)

55.993 Skin Cancer Prevention
HD 10/22/2017
MAG supports AMA policies on skin cancer prevention, which include, but not limited to, promoting early detection screenings, recognizing the first Monday of May as Melanoma Monday and the

effectiveness of sunscreen in preventing skin cancer, and supports access to sunscreen dispensers in places of public accommodations, and the implementation of skin cancer prevention education programs in U.S. educational institutions. (Res. 109A.17)

55.994 Colorectal Cancer Screening

HD 10/18/2015
MAG endorses efforts to improve colorectal cancer outcomes in Georgia by increasing the screening rate in Georgia from 67.8 percent to 80 percent by 2018 for adults over the age of 50. (Resolution 110A.15).

55.995 Access to Palliative Care

HD 10/18/2015
MAG supports all efforts including those of the Georgia Cancer Control Consortium and other health care organizations, including legislation to create a palliative care network that offers access to palliative care for both inpatient and outpatient treatment in each region of the state. (Resolution 103A.15)

55.996 Cancer Prevention

HD 10/20/2012
MAG supports proven strategies and activities aimed at prevention of cervical cancer in Georgia such as education, regular health exams and the use of cervical cancer preventing vaccines for all age groups (Special Report Appendix III; 10/21/2017)

55.998 Cancer Screening

HD 10/13/2007
MAG supports all efforts aimed at maintaining and increasing the rate of pap smears and cervical cancer screenings completed in Georgia; and opposes initiatives that would decrease access to and completion of pap smears. (Resolution 103A.07) (Reaffirmed 10/20/12; 10/21/2017)

55.999 Cancer Registry

HD 4/1/1987
MAG supports the Central Cancer Registry and encourages hospitals to participate in reporting information to the Central Registry; MAG continues to encourage hospitals to develop hospital cancer programs and gain approval of these programs by survey from the Commission on Cancer of the American College of Surgeons. (Reaffirmed 5/2000, 10/2009; 10/2014; 10/20/2019)

60
Children and Youth

60.989 Education -- Physical Activity

HD 10/21/2012 MAG supports minimum requirements for physical activity for school children in grades K through 12. (Res. 109A.12; Reaffirmed 10/21/2017)

60.990 Hepatitis B Immunizations

HD 9/30/2006
MAG supports public health rules which require children to be immunized for Hepatitis B prior to enrollment in school or daycare centers. (Reaffirmed 10/16/2011; 10/15/2016)

60.991 Harassment in Schools

EC 9/16/2001

MAG opposes harassment, bullying or discrimination in schools based on race, religion, national origin, ethnicity, sex, age, sexual orientation, and physical disabilities. Such behavior can and does have a negative impact on the health and well-being of our school children and others. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

60.992 Children's Immunization and Screening

HD 5/19/2001

MAG supports the immunization, visual testing and hearing screening standards currently in practice for public schools and recommends that they be expanded to include all private and home schooled school-age children. (Res: 312C-01, Res.1) (Reaffirmed 9/3/2006; 10/16/2011; 10/15/2016)

60.993 AMA Guidelines for Adolescent Prevention Services

HD 4/1/1996

MAG endorses the AMA Guidelines for Adolescent Prevention Services and encourages physicians to provide services to adolescents in Georgia. (Reaffirmed 05/2002; 10/13/2007; 10/20/12; 10/21/2017)

60.996 Medical Services --Youth Detention Facilities

HD 4/1/1992

MAG supports adequate and appropriate medical, psychological, and basic health services for individuals detained in Georgia's youth detention centers. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

60.997 Health Screening Student Athletes

HD 4/1/1991

MAG supports immunity for physicians who provide, in good faith, free health screening services for student athletes. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

60.999 Health Risk Appraisal Program

HD 4/1/1988

MAG supports promotion of high school health risk appraisal programs. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

70
Coding and Nomenclature

70.999 Current Procedural Terminology (CPT)

EC 3/1/1981

MAG endorses and encourages physicians to use the applicable edition of the AMA Current Procedural Terminology (CPT) as the common coding system for use in identifying services performed for insurance and other third party payer programs. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

75
Contraception

75.999 Prevention of Undesired Pregnancies
HD 4/1/1993
MAG supports expanded state funding of public health and Medicaid programs for the prevention of undesired pregnancies. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

85
Death

85.992 Death - Definition
HD 10/17/2009
MAG has accepted the basic tenets of the World Health organization's statement on death: "The point of death of the different cells and organs is not so important as the certainty that the process has become irreversible by whatever techniques of resuscitation that may be employed. This determination will be based on clinical judgment supplemented, if necessary, by a number of diagnostic aids including brain flow scans. However, no single technological criterion is entirely satisfactory in the present state of medicine nor can any technological procedure be substituted for the overall judgment of the physician." (Special Report: Appendix III; Reaffirmed 10/2014; 10/20/2019)

85.993 Executions
HD 10/13/2007
MAG believes that physicians should be involved in the pronouncement of death at prison executions. (Resolution 217B.07) (Reaffirmed 10/20/2012; 10/21/2017)

85.994 Medical Examiners System - Coroners
HD 4/1/1989
MAG supports the establishment of an independent and permanent Board to direct and oversee the development and operation of the Medical Examiners System. The Board should be composed of members of the legal and medical profession, of law enforcement representatives and of citizens-at-large, all of whom, because of their special knowledge or interest, can provide meaningful contributions to such Board. The Georgia State Crime Laboratory should also be supervised by the Board. (Reaffirmed 5/2000, 10/2009; 10/2014; 10/20/2019)

85.997 Opposition to the Coroners System
HD 4/1/1983
MAG supports the concept of a statewide medical examiners system rather than an elected county coroner system. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

95
Drug Abuse

95.999 Drug-Free Workplace in Physician Office
HD 4/1/1993
MAG requests that Georgia physicians establish drug free workplace programs for their practices. (Reaffirmed 05/2000; 10/5/2008; 10/20/13; 10/20/2018)

100
Drugs

100.992 Medical Marijuana --Cannabinoids
BD 1/26/2019
MAG supports the removal of any and all barriers to further research of cannabinoids, and supports any actions that will lead to the production of safe and quality-controlled cannabinoid extracts that can be produced within Georgia for patients on the state "medical marijuana registry." (BOD action on HOD Resolution 311C.18)

100.993 Medication Assisted Therapy
HD 10/21/2018
MAG shall: 1) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.; 2) publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of opioid use disorder; and 3) support eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder. (Resolution 106.18)

100.994 Destruction of Drugs -- Safety
HD 10/22/2017
MAG, for the destruction of drugs, supports the safe and convenient placement of drug drop boxes in neighborhood retail pharmacies or other appropriate locations through legislative and/or policy changes (Res. 603S.17)

100.995 Prescription Drug Monitoring Program
BD 1/28/2017
MAG opposes any mandatory Prescription Drug Monitoring Program (PDMP) check by physicians on every narcotic medication prescribed.

100.996 Prescription Drug Monitoring
HD 10/20/2013
MAG supports interstate communications between prescription drug monitoring programs in jurisdictions with privacy protections for patients and physicians. (resolution 304C.10) (reaffirmed 10/20/2013; 10/20/2018)

100.997 Narrow Therapeutic Index
HD 9/30/2006
MAG supports prohibition of any substitutions of a prescribed medication with a narrow therapeutic index with another manufacturer's form of the same medication with a narrow therapeutic index on a state or federal prescription drug plan chosen by the patient, without first submitting written or electronic notifications of such change by the formulary to the patient and prescribing physicians. (Reaffirmed 10/16/2011; 10/15/2016)

100.998 Drug Endorsements
HD 10/15/2005
MAG will not engage in any endorsement of a drug or drugs for commercial purposes. (Comm. 01-05 Appendix III) (Reaffirmed 10/16/2010; 10/17/2015)

100.999 Advertising Prescriptions
HD 5/4/2002
MAG strongly objects to the marketing of pharmaceutical products through direct media advertising to the general public. (Res: 102AB-02 and Res: 105AB-02) (Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

110
Drugs: Cost

110.997 Drug Pricing Transparency
HD 10/22/2017
MAG shall, in cooperation with specialty societies, advocate for legislation that will prohibit price gouging in Georgia on off-patent medications where there are fewer than three manufactures and where there have been no external factors to justify the price increase. (Res. 107A.17)

110.998 Truth in Prescription Costs -- Education
HD 10/22/2017
MAG supports the AMA's efforts to educate the public on the high costs of prescription drugs and shall promote the TruthInRx website to Georgia physicians and patients. (Res. 106A.17)

110.999 Drug Costs and Access
HD 10/22/2017
MAG supports the efforts of the Alliance for Transparent and Affordable Prescriptions (ATAP) and its mission to address prescription drug costs and patient access to affordable treatment through the following measures: 1) regulating pharmacy benefit manager (PBM) practices; and 2) reform of the drug industry through educational outreach and grassroots advocacy initiatives at both the state and federal levels. (Res. 103A.17)

115
Drugs: Labeling and Packaging

115.999 Package Inserts
HD 10/21/2019
MAG shall advocate for generic drugs to have an FDA-approved package insert available when dispensed that will disclose active and inactive ingredients, and clear language with bio-equivalent data as compared to parent branded drugs. (Res. 102A.18)

120
Drugs: Prescribing and Dispensing

120.968 DXM -- Minors' Access
HD 10/21/2018
MAG strongly supports state-level legislation to restrict minors’ access to medicine containing dextromethorphan (DXM). (Resolution 310C.18)

120.969 Prescribing by Physicians & Supervised Personnel
HD 10/21/2018
MAG supports the following Prescribing Principles: 1) Only physicians, physician assistants (under physician delegation) and advanced practice nurses (under protocol with a supervising physician), dentists, veterinarians or podiatrists are qualified to prescribe drugs under Georgia law and the Georgia Legislature should not authorize unqualified practitioners to prescribe drugs; 2) Physicians should write prescriptions for a specified length of time and pharmacists are urged not to fill prescriptions past the time marked; 3) MAG believes in the education of physicians and pharmacists regarding all phases in the prescription of medications, including prescribing, writing, signing, sampling and distribution of all drugs as covered in the Georgia Pharmacy Act; 4) Advance Practice Nurses should continue to perform medical acts under the written clinical nurse protocol of physician and not as independent agents; and 5) Medical acts performed by advance practice nurses on orders/written clinical nurse protocol of the physician, should be billed by the physician (medical acts as distinguished from nursing acts). (Special Report 03.18, Appendix I)

120.970 Physician Prescribing Data
HD 10/21/2017
MAG supports AMA efforts to limit access to physicians prescribing data by allowing physicians to opt out of having personal information released through its Prescription Data Restriction Program. (Special Report, Appendix III)

120.971 Syringes and Needles
HD 10/16/2016
MAG strongly supports the ability of physicians to prescribe syringes and needles to patient with injection drug addiction in conjunction with addiction counseling to help prevent the transmission of contagious diseases...Res. 608S.16)

120.972 Naloxone --Dispensing
HD 10/16/2016
MAG supports over-the-counter dispensing of intranasal naloxone through standing orders or collaborative practice agreements for use in a manner consistent with state laws. (Res. 607S.16)

120.973 Opioid Prescribing -- Voluntary CME
HD 10/16/2016
MAG supports voluntary continuing medical education (CME) for all physicians as it pertains to the prescribing of opioids.(Res. 606S.16)

120.974 Drug Formulary Transparency
HD 10/18/2015

MAG support drug formulary transparency for patients to help improve the quality of care provided by physicians. (Res. 307C.15, resolve 2)

120.975 APRN Prescribing Under Protocol

BD 10/16/2015

MAG believes that APRNs: 1) should not prescribe drugs for a treatment of an unconfirmed medical diagnosis; 2) are trained only to enter a nursing diagnosis for a patient and should not enter an non-established medical diagnosis for a patient; and 3) should be governed by the Georgia Composite Medical Board.

120.976 Vaccines Protocol

HD 10/19/2014

MAG shall: 1) oppose expansion of prescriptive authority in prescribing and administering vaccines by blanket protocol beyond the current administration of the annual influenza vaccine; 2) endorse vaccine education by all members of a medical team including pharmacists; and 3) endorse appropriate reimbursement for vaccine costs and administration. (Res. 312C) (Reaffirmed 10/20/2019)

120.977 Physician Assistants Prescribing

BD 01/25/2014

MAG oppose legislation that will allow physician assistants the delegated authority to prescribe Schedule II drugs. (Reaffirmed 10/20/2019)

120.978 Limited Preferred Drugs

HD 10/20/2013

MAG supports on all drug benefit plans at least one drug in all drug classes be represented in preferred status. (Res. 307C.13; Reaffirmed 10/20/2018)

120.979 Proton Pump Inhibitors

HD 10/20/2012

MAG opposes implementation of prior approval requirements for proton pump inhibitors, as harmful to patients and an ineffective cost saving measure. (Special Report Appendix III; Reaffirmed 10/21/2017)

120.980 Drug Formularies Transparency

HD 10/16/2011

MAG supports transparency in a patient's formulary information allowing for medical decisions to be made at the point of care including streamlining administrative process through electronic prior authorizations with all costs of implementation being borne by health insurers and/or pharmaceutical companies. (Res. 111A.11, Resolve 3) (Reaffirmed 10/15/2016)

120.981 Specialty Medication Financial Discriminations

HD 10/16/2011

MAG supports patient protections that prohibit health plans from financial discriminations to patients based on diagnosis and need for specialty medications, and plans that allow for reasonable patient costs. (Res. 111A.11, Resolve 2) (Reaffirmed 10/15/2016)

120.984 Step Therapy

HD 10/13/2007

MAG opposes any contractual requirement that requires the use of step therapy from any public or private

third party payer. (Appendix III -Committee 01.07) (Reaffirmed 10/20/2012; 10/21/2017)

120.985 Physician Prescribing

HD 10/16/2010

MAG supports the physician's right to prescribe individual drugs which are appropriate for the medical condition in question, Committee 4.10: Appendix III (Reaffirmed 10/17/2015)

120.986 Dispensing Legally Valid Prescriptions

EC 2/26/2006

MAG supports legislation that requires pharmacists to fill legally valid prescriptions; however in the case of a pharmacist who has issued a written objection to dispensing abortion drugs, such pharmacist shall provide immediate referral to an appropriate alternative dispensing pharmacy, and immediately return the prescription to the prescription holder, without interference. (Reaffirmed 10/16/2011; 10/15/2016)

120.987 Standard Indigent Drug Assistance

HD 8/22/2003

MAG supports a single patient assistance drug plan administered by pharmaceutical companies for those in financial need with one card and one set of rules for administration, so that doctors can write prescriptions which can be taken to pharmacies and patients can make a viable co-pay based on income. (Resolution 103AB-03) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

120.991 Medication Step Care Therapy

HD 5/19/2001

MAG denounces, in principle, Medication Step Care Therapy programs when implemented as an inflexible or administratively burdensome method to contain pharmacy costs as a part of a Pharmacy Benefit Management Program or any pharmacy cost savings approach. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

120.992 Pharmacists Modifying Drug Therapy

HD 10/16/2010

MAG supports the ability of pharmacists to modify drug therapy in an institutional setting pursuant to the order of a physician or a protocol established by the medical staff, or under the following circumstances: 1) Patient specific; 2) Pursuant to a physician's diagnosis; 3) Physician set parameters (no therapeutic substitution); 4) Specifics on types and categories of medication as well as minimum and maximum dosage levels within types and categories; 5) Mandatory reporting back to physicians, 6) Patient notified that pharmacists is authorized to modify drug therapy; 7) Physician readily available for consultation and direction; and 8) A one-time modification, (Special Report 04.10 III (Reaffirmed 10/17/2015)

120.994 Misuse of DEA Number

HD 5/1/1998

MAG supports the proper use of the DEA number, which is only used for the prescribing of controlled substances. (Res: 315C-98) (Reaffirmed 10/2005; 10/16/2010l; 10/17/2015)

120.995 Prescribing Practices

HD 5/1/1998

MAG opposes the practice of permitting pharmaceutical manufacturers access to specific physician prescribing practices, Res: 101-A-98 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

120.996 Utilization of Unused Unit Dose Medicines
HD 4/1/1991
MAG supports appropriate mechanisms to permit the utilization of unused unit dose medicines. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

120.997 Physician Dispensing Oversight
HD 4/1/1988
MAG supports the Georgia Composite Medical Board's oversight of physician dispensing. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

120.998 Physician Dispensing
HD 4/1/1988
MAG affirms the physician's right to dispense medicine along appropriate guidelines. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

125
Drugs: Substitution

125.991 Biosimilar medications
HD 10/19/2014
MAG shall promote legislation or regulation addressing prescribing issues for biologics, including: 1) a requirement ensuring that if a brand biologic medication is prescribed to a patient, that patient receives the specific brand medication; 2) notification to both the physician and patient before any biosimilar medication, either interchangeable or non-interchangeable, is substituted for a biologic medication; 3) a requirement that a non-interchangeable biosimilar is not allowed, a substitution must be done with an interchangeable biosimilar and not a non-interchangeable biosimilar; and 4) a requirement that pharmacists and prescribers retain records of patients who receive biosimilars for a set period of time. (Res. 304C) (Reaffirmed 10/20/2019)

125.992 Biologic Medication Substitution
HD 10/19/2014
MAG shall oppose any insurance program that requires patients stabilized on biologic therapy to be required to switch to another biologic medication. (Res. 302C.14 (Reaffirmed 10/20/2019)

125.993 Principles for Generic Substitution of Drugs
HD 10/4/2008
Principles for Generic Substitution of Drugs
1. MAG reaffirms its previous policy that all physicians be urged to supplement medical considerations with cost considerations when selecting the drug of choice for an individual patient and to become well informed about the quality of prescription drug products available from multiple sources.

2. Until the methodology for approval of bioequivalence and therapeutic equivalence of all drug products is resolved, MAG reaffirms its previous policies: a) that the dose of any medication continue to be titrated for optimum efficacy and safety, especially in patients with chronic disorders who require prolonged therapy or patients in special population groups not expected to respond to a drug in the normal manner; b) when multiple refills of a drug product for chronic diseases are anticipated, physicians should avoid substitution unless the products have been proven to be bioequivalent, and c) when serious or unusual

problems develop that may be related to drug substitution, the findings should be documented. A short federal Food and Drug Administration (FDA) reporting form is available on the last page of the FDA Drug Bulletin, which is sent quarterly to all practicing physicians. Physicians are urged to include the manufacturer and lot number of the drug product in the 1639 form.

3. MAG believes that the physician and pharmacist should take necessary steps to eliminate confusion to the patient when labels are changed as a result of any drug substitution, particularly when the color, shape, and taste of drug substitute vary from the originally prescribed product.

4. Pharmacists should not substitute any generic drug product that has a B bioequivalent rating (i.e., potential of documented bioinequivalent problem). All B-related drug products should be required to demonstrate bioequivalence, or their application should be withdrawn by the FDA.

5. Physicians should become familiar with specific laws governing generic drug substitution in their state and, where applicable, they should obtain a copy of the state's current generic substitution drug formulary.

6. The only text currently available for determining equivalence among drug products (i.e., Approved Drug Product With Therapeutic Equivalence Evaluations (the Orange Book or The List) should be revised as follows: Although the FDA is mandated to do so, single-source drugs should be eliminated. The manufacturing source for all multisource drug products should be included, even if it requires a rapid update system, possibly on-line, for the pharmacist. The inclusion of decisional criteria for determining bioequivalence and therapeutic equivalency of selected agents is recommended.

7. The FDA should proceed without undue delay to implement an imprint coding system for all solid oral dosage forms that allows identification of the manufacturing source of the product even if a non-manufacturing distributor is involved. This will markedly aid the physician, the pharmacist, and the patient to know when drug substitution has occurred and will help to resolve causality if a drug product failure has occurred.

8. Selected post-marketing surveillance systems (other than spontaneous reporting) of adverse events should be explored by the FDA. Especially meaningful, might be studies that provide data on: a. A comparison of elderly patients with associated multiple diseases and/or on multiple drug therapy in whom the drug will be used, but who are not representative of the group in which the drug was tested for bioequivalency; b. Studies in patients compared with the group in whom the drug was tested when a number of active metabolites of a drug known to be present in different proportions than the test group; and c. Studies when the therapeutic index of a drug is quite narrow.

9. Congress should support the generic drug review and approval process with adequate personnel and financial resources for the FDA. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

125.994 Substitutions

HD 10/16/2010

MAG opposes therapeutic substitution and the requirements that "Brand Necessary" be handwritten on hardcopy prescriptions to prevent generic substitution. MAG supports authorizing physicians to orally designate a prescription as "Brand Necessary" via the telephone, and reversion to the "double line" hardcopy prescription on which the physician signs the appropriate line related to generic substitutions, Appendix III (Reaffirmed 10/17/2015)

125.997 Prescription Labeling

HD 4/1/1989

MAG supports labeling on all prescriptions dispensed to non-hospitalized patients which would show the generic name and the brand name when a brand name is substituted with a generic drug as follows: Generic Name substituted for Trade Name as in "Furosomide substituted for Lasix." (Reaffirmed 5/2000; 10/5/2008; 10/20/201; 10/20/2018)

125.999 Prior Approval for Generic Drug Substitution

HD 10/19/2019

General drug substitution by pharmacists and pharmacy benefit managers (PBMS) without prior approval by the physician is not in the best interest of the patient because medical determinations concerning the prescription would no longer be made by the physician who has responsibility for the patient's health. Special Report 3.19, Appendix III

130
Emergency Medical Services System

130.965 Disaster Medical Response

HD 10/20/2013

MAG has a statewide role in assisting with disaster preparation and response by: 1. Encouraging members to become informed about the topic of disaster readiness as it pertains to the physician practice environment (i.e., continuity of operations planning); 2. educating practicing physicians and physicians-in-training on the principles of disaster medicine; 3. identifying the role of the practicing physician in mitigating risk in the community; 4. identifying physicians in the State of Georgia who would be willing and able to respond to mass casualty situations; and 5. mobilizing trained volunteer physicians in response to established medical need at a mass casualty site. (Special Report 04.13, Appendix III; Reaffirmed 10/20/2018)

130.966 Call Coverage

HD 10/20/2012

MAG recognizes that access to specialists across the state’s hospital emergency departments has deteriorated, particularly in rural areas, while at the same time the number of patients accessing hospital emergency departments has increased. An increasing number of specialties are no longer aligned with specific hospitals or medical staffs making it more difficult to gain traditional coverage from medical staffs. Although hospital payment for emergency room coverage has improved, it is uneven throughout the state and is non-exist in some hospitals. MAG will continue to serve as an information clearing house for physicians in Georgia and to monitor emergency department call coverage for the provision of emergency services and disaster preparedness and for the adequacy of support of physicians providing this critical service. MAG strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage. (Special Report Appendix III' Reaffirmed 10/21/2017)

130.967 Medical Response & Preparedness

HD 10/16/2011

MAG condemns terrorism in all its forms and believes that physicians have an obligation to provide urgent medical care during disasters; it will take a primary role in coordinating physician efforts with public health's response to terrorism planning and other disasters as spelled out in Georgia's Emergency

Operations Plan. MAG advocates for a functional medical component of the state disaster plan and adequate funding for ongoing development of the state plan; it will work collaboratively with the Georgia Department of Public Health Emergency Medical Services office, the Georgia Emergency Management Agency, county medical societies, county health departments, hospitals and others, on an ongoing basis: (a) in preparing for epidemics, terrorist attacks, and other disasters; physicians as a profession must provide medical expertise and work with others to develop public health policies that are designed to improve the effectiveness and availability of medical care during such events; (b) in the development, dissemination, and production of regional and statewide education and training initiatives to provide physicians, professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts; MAG strongly encourages medical schools to teach their students the principles of triage, chain of command teamwork protecting themselves from becoming victims, and identifying and mobilizing resources; we also strongly encourage the Georgia residency programs to teach these principles of disaster medicine to their residents; (c) to develop a comprehensive strategy to assure surge capacity to address mass casualty care; (d) to implement communications strategies to inform professionals and the public about a terrorist attack or other major disaster; (e) to convene local and regional workshops to share "best practices" and "lessons learned" from disaster planning and response activities; (f) to urge individual physicians to take appropriate advance measures to ensure their ability to provide medical services at the time of disasters, including the acquisition and maintenance of relevant knowledge of disease surveillance and control, disease signs and symptoms, diagnosis, treatment, isolation precautions, decontamination protocols, and chemotherapy/prophylaxis against radioactive agents likely to be used in a terrorist attack, and (g) MAG supports utilizing the Division of Public Health's Physician/Health Professional Emergency Reserve Corps and the Georgia State Defense Reserve Corps, including qualified retired physicians, as volunteers to hospitals, local health departments, or other medical outpatient facilities in the event of a national disaster or any public health emergency situation. All emergency programs such as these must have a system to assure that those who are involved are legally certified and/or licensed and that the process can be implemented expeditiously. MAG supports state legislation and/or funding to the Georgia Division of Public Health for the development of a standardized identification program/badge or credentials for all emergency personnel, including physicians. (Special Report: 04.11, Attachment III) (Reaffirmed 10/15/2016)

130.968 Hospital Diversion

HD 10/16/2011

MAG: 1) supports hospital "diversion policies" which are developed by emergency room physicians, in coordination with nursing and/or administrative staff, national medical society expertise, (American College of Emergency Physician Guidelines) and with elected medical staff leadership; 2) recognizes that hospitals share the responsibility for emergency care coverage in a given geographic region and throughout the state. Consequently, MAG supports the establishment of local, multi-organizational task forces, with representation from hospital medical staffs, to devise local solutions to the problem of emergency department overcrowding, ambulance diversion, and physicians on-call coverage, and encourage the exchange of information among these groups. (Special Report: 04.11, Attachment III) (Reaffirmed 10/15/2016)

130.973 State Trauma System

HD 10/16/2010

MAG supports a fully funded and staffed statewide coordinated trauma system for Georgia in which highly specialized services are concentrated in designate regional trauma centers and that provides for the direct referral of patients to the nearest appropriate regional center. MAG promotes the retention of a physician Director for the Department of community Health's (DCH) EMS and Trauma Services Office. MAG supports annual incentive payments to designated trauma centers that meet the DCH/EMS and

American College of Surgeons standards. Such payments should be from a dedicated source that is not subject to being appropriated elsewhere, should assist physicians and other health care providers defray the costs of uncompensated care, and should be made through the EMS and Trauma Services Office. MAG supports the development of a statewide trauma registry to be used for quality assurance, improved patient care and for research on the overall impact of trauma on the state's healthcare system, citizens and economy, Special Report 04.10, III(Reaffirmed 10/17/2015)

130.975 Call Coverage -- Physician Compensation

BD 5/17/2003

MAG encourages hospitals to contract with and compensate physicians to provide on-call emergency services. (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

130.976 Emergency Department Call Panels

BD 5/17/2003

A physician's participation on a hospital's emergency department backup call panel shall be voluntary and shall not be required as a condition of medical staff privileges. (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

130.977 Chemical Attack and EMS Personnel

HD 5/4/2002

MAG supports allowing EMS personnel to self-administer and administer to others the Mark I kits in the event of an apparent chemical attack with nerve agents. EMS personnel should be able to assist in setting up the "push packs" from the National Pharmaceutical Stockpile and administer antibiotics, immunizations, and vaccinations at times of a declared disaster. (Committee: 9-02, Rec. 3) (Reaffirmed 10/13/07; 10/20/2012; 10/21/2017)

130.979 EMS Oversight

HD 5/4/2002

MAG supports the establishment of the EMS Medical Directors Advisory Council as the physician advisory and oversight body for the state EMS Medical Director and for the Office of EMS. (Committee: 9-02, Rec. 2) (Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

130.988 Call Coverage

HD 5/1/2000

MAG supports retraction of onerous provisions of EMTALA and OIG opinions concerning emergency room call coverage by physicians, Res: 209B-00 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

135
Environmental Health

135.998 Preventing Destruction of the Ozone Layer

HD 4/1/1992

MAG actively supports the ongoing efforts to reduce the destruction of the ozone layer and believes the United States of America should follow the lead of Germany in stopping the production of ozone-destroying chemicals (CFCs). The U.S. should actively try to safely remove all CFCs presently in use in this country. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

135.999 Recycling in Physician Offices
HD 4/1/1992
MAG urges all of its members to practice basic recycling in their homes and offices and asks the MAG administrative office to continue to recycle whenever possible. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

140
Ethics

140.971 Inappropriate Medical Treatment -- Response
BD 1/26/2019
MAG supports the following American Thoracic Society's policy recommendations when responding to potential medically inappropriate treatments.

Recommendation 1
Institutions should implement strategies to prevent intractable treatment conflicts, including proactive communication and early involvement of expert consultation.

Recommendation 2
The term "potentially inappropriate" should be used, rather than "futile," to describe treatments that have at least some chance of accomplishing the effect sought by the patient, but clinicians believe that competing ethical considerations justify not providing them. Clinicians should communicate and advocate for the treatment plan they believe is appropriate. Requests for potentially inappropriate treatment that remain intractable despite intensive communication and negotiation should be managed by a fair process of dispute resolution, and recommending the following approach to manage such cases: 1) enlist expert consultation to continue negotiation during the dispute resolution process; 2) give notice of the process to surrogates; 3) obtain a second medical opinion; 4) obtain review by an interdisciplinary hospital committee; 5) offer surrogates the opportunity to transfer the patient to an alternate institution; 6) inform surrogates of the opportunity to pursue extramural appeal; 7) implement the decision of the resolution process.

When time pressures (such as a rapidly deteriorating clinical condition) make it infeasible to complete all steps of the conflict-resolution process and clinicians have a high degree of certainty that the requested treatment is outside accepted practice, they should refuse to provide the requested treatment and endeavor to achieve as much procedural oversight as the clinical situation allows.

Recommendation 3
There are two less-common situations for which the committee recommends different management strategies.

Requests for strictly futile interventions.
The term "futile" should only be used in the rare circumstance that an intervention simply cannot accomplish the intended physiologic goal. Clinicians should not provide futile interventions and should carefully explain the rationale for the refusal. If disagreement persists, clinicians should generally obtain expert consultation to assist in conflict resolution and communication.

Requests for legally proscribed or legally discretionary treatments.
"Legally proscribed" treatments are those that are prohibited by applicable laws, judicial precedent, or

widely accepted public policies (e.g., organ allocation strategies). “Legally discretionary” treatments are those for which there are specific laws, judicial precedent, or policies that give physicians permission to refuse to administer them. In responding to requests for either legally proscribed or legally discretionary treatments, clinicians should carefully explain the rationale for treatment refusal and, if there is uncertainty regarding the interpretation and application of the relevant rule, should generally seek expert consultation to confirm accurate interpretation of the rule.

Recommendation 4
The medical profession should lead public engagement efforts and advocate for policies and legislation about when life-prolonging technologies should not be used.

140.972 Gifts to Physicians

HD 10/21/2018
MAG urges physicians to comply with the following American Medical Association (AMA) policy on gifts to physicians from the industry.

Code of Medical Ethics Opinion 9.6.2 Relationships among physicians and professional medical organizations and pharmaceutical biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties. Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients. To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should: (a) decline cash gifts in any amount from an entity that has a direct interest in physicians' treatment recommendations: (b) decline any gifts for which reciprocity is expected or implied and (c) accept an in-kind gift for the physician's practice only when the gift will i) directly benefit patients, including patient education ii) is of minimal value; (d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students,' residents,' and fellows' participation in professional meetings, including educational meetings, provided: i) the program identifies recipients based on independent institutional criteria and ii) funds are distributed to recipients without specific attribution to sponsors.(Special Report 03.18, Appendix III)

140.973 Nonscientific treatment

HD 10/18/2014
Any treatment which has no scientific basis constitutes a hazard to health care, tends to deceive the patient by giving him false hope, and may cause the patient to delay seeking proper care until his condition becomes irreversible. Medications that have not been FDA approved shall not be considered absent scientific basis if there is conclusive evidence of its ability to improve a health outcome. The public should be informed about the nature of any purported treatment program which has no scientific basis, and the medical profession is well qualified and has a professional responsibility to inform the public regarding such programs. Physical examinations, such as school athlete examinations, should not be performed by nonscientific practitioners but should be performed by those practitioners licensed and qualified to identify all possible conditions reasonably related to the activity to be undertaken by the patient. (Special Report 4: Attachment III) (Reaffirmed 10/20/2019)

140.974 MAG's Ethical Principles of Managed Care

HD 10/15/2016
MAG opposes any de-selection of physicians from managed care plans based on physicians reporting of

any managed care deviations from these ethical guidelines. MAG also adopts the following principles related to the effect of managed care (i.e., IPAs, PPOs, HMOs and ACOs) on the patient/physician relationship and advocates for governmental leaders to take appropriate actions to ensure that no entity inserts itself between the physician and his/her ability to treat and care for his/her patient: (1) that the physician/patient relationship is a covenant that is sacrosanct. This covenant includes concern for the patient, advocacy on behalf of the patient and a desire to assist in the healing of the patient; (2) that the profit motives and inappropriate cost containment strategies currently influencing the entire health care delivery system threatens to transform this covenant into a mere business contract; (3) that medicine and nursing must not be diverted from their primary tasks, which include the relief of suffering, the prevention and treatment of illness and the promotion of health; (4) that financial incentives that reward inappropriate care, whether through over utilization or under-utilization of health care services, should be prohibited; (5) that all patients should have the freedom to choose any physician they desire to see; (6) that all patients should have access to affordable health care coverage; (7) that health care decisions should be based on concern for the individual, and patients should be treated with dignity, compassion and respect; (8) in no way is this to be construed as support for a single payer national health care system; (9) MAG supports studies which address the impact and ethical implications of financial incentives, including discounted fee for service, withholds and capitated payments, on the quality of patient care delivered in managed care plans and on patient access to specialty care. (Consent Calendar Appendix III)

140.975 Patient Responsibilities

HD 10/17/2010

MAG adopts AMA Opinion E-10.02 --Patient Responsibilities and includes the following as number 12: Physicians and hospitals should not be penalized when patients do not meet their responsibilities, Resolution 103A.10 (Reaffirmed 10/17/2015)

AMA Opinion 10.02 – Patient Responsibilities

It has long been recognized that successful medical care requires an ongoing collaborative effort between patients and physicians. Physician and patient are bound in a partnership that requires both individuals to take an active role in the healing process. Such a partnership does not imply that both parties have identical responsibilities or equal power. While physicians have the responsibility to provide healthcare services to patients to the best of their ability, patients have the responsibility to communicate openly, to participate in decisions about the diagnostic and treatment recommendations, and comply with the agreed-upon treatment program.

Like patients' rights', patients' responsibilities are derived from the principle of autonomy. The principle of patient autonomy holds that an individual's physical, emotional, and psychological integrity should be respected and upheld. This principle also recognizes the human capacity to self-govern and choose a course of action from among different alternative options. Autonomous, competent patients assert some control over the decisions which direct their healthcare. With that exercise of self-governance and free choice comes a number of responsibilities.

1. Good communication is essential to a successful patient-physician relationship.
2. Patients have a responsibility to provide a complete medical history, to the extent possible, including information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.
3. Patients have a responsibly to request information or clarification about their health status or treatment when they do not fully understand what has been described.
4. Once patients and physicians agree upon the goals of therapy and a treatment plan, patients have a responsibility to cooperate with a treatment plan and to keep their agreed-upon appointments. Compliance with physician instructions is often essential to public and individual safety. Patients also

have a responsibility to disclose whether previously agreed upon treatments are being followed and to indicate when they would like to reconsider the treatment plan.
5. Patients generally have a responsibility to meet their financial obligations with regards to medical care or to discuss financial hardships with their physicians. Patients should be cognizant of the costs associated with using a limited recourse like healthcare and try to use medical resources judiciously.
6. Patients should discuss end-of-life decisions with their physicians and make their wishes known. Such a discussion might also include writing an advance directive.
7. Patients should be committed to health maintenance through health-enhancing behavior. Illness can often be prevented by a healthy lifestyle, and patients should take personal responsibility when they are able to avert the development of disease.
8. Patients should also have active interest in the effects of their conduct on others and refrain from behavior that unreasonably places the health of others at risk. Patients should inquire as to the means and likelihood of infectious disease transmission and act upon that information which can best prevent further transmission.
9. Participation in medical education is to the mutual benefit of patients and the health care system. Patients are encouraged to participate in medical education by accepting care, under appropriate supervision from medical students, residents, and other trainees. Consistent with the process of informed consent, the patient or the patient's surrogate decision maker is always free to refuse care from any member of the health care team.
10. Patients should discuss organ donation with their physicians, and if donation is desired, make applicable provisions. Patients who are part of an organ allocation system and await needed transplant should not try and go outside of or manipulate the system. A fair system of allocation should be answered with public trust and an awareness of limited resources.
11. Patients should not initiate or participate in fraudulent health care and should report illegal or unethical behavior by physicians and other providers to the appropriate medical societies, licensing boards, or law enforcement authorities.
12. Physicians and hospitals should not be penalized when patients do not meet their responsibilities.

140.976 Physician Billing Practices

BD 10/3/2008
MAG will take no legislative advocacy position contrary to the following AMA Ethics policies: (Reaffirmed 10/19/2013; 10/21/2018)
E-6.02 Fee Splitting
Payment by or to a physician solely for the referral of a patient is fee splitting and is unethical. A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All 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. (II) Issued prior to April 1977; Updated June 1994.
E-6.09 Laboratory Bill
When it is not possible for the laboratory bill to be sent directly to the patient, the referring physician's bill to the patient should indicate the actual charges for laboratory services, including the name of the laboratory, as well as any separate charges for the physician's own professional services. (II) Issued prior to April 1977.
E-6.10 Services Provided by Multiple Physicians
Each physician engaged in the care of the patient is entitled to compensation commensurate with the value of the service he or she has personally rendered. No physician should bill or be paid for a service which is not performed; mere referral does not constitute a professional service for which a professional

charge should be made or for which a fee may be ethically paid or received. When services are provided by more than one physician, each physician should submit his or her own bill to the patient and be compensated separately, if possible. A physician should not charge a markup, commission, or profit on the services rendered by others. It is ethically permissible in certain circumstances, however, for a surgeon to engage other physicians to assist in the performance of a surgical procedure and to pay a reasonable amount for such assistance, provided the nature of the financial arrangement is made known to the patient. This principle applies whether regardless of the assisting physician is the referring physician. (II) Issued prior to April 1977; Updated June 1994.

E-8.09 Laboratory Services

(1) A physician should not misrepresent or aid in the misrepresentation of laboratory services performed and supervised by a non-physician as the physician's professional services. Such situations could involve a laboratory owned by a physician who directs and manages its financial and business affairs with no professional medical services being provided; laboratory work being performed by technicians and directly supervised by a medical technologist with no participation by the physician; or the physician's name being used in connection with the laboratory so as to create the appearance that it is owned, operated, and supervised by a physician when this is not so. (2) If a laboratory is owned, operated, and supervised by a non-physician in accordance with state law and performs tests exclusively for physicians who receive the results and make their own medical interpretations, the following considerations would apply: The physician's ethical responsibility is to provide patients with high quality services. This includes services that the physician performs personally and those that are delegated to others. A physician should not utilize the services of any laboratory, irrespective of whether it is operated by a physician or non-physician, unless she or he has the utmost confidence in the quality of its services. A physician must always assume personal responsibility for the best interests of his or her patients. Medical judgment based upon inferior laboratory work is likewise inferior. Medical considerations, not cost, must be paramount when the physician chooses a laboratory. The physician who disregards quality as the primary criterion or who chooses a laboratory solely because it provides low-cost laboratory services on which the patient is charged a profit, is not acting in the best interests of the patient. However, if reliable, quality laboratory services are available at lower cost, the patient should have the benefit of the savings. As a professional, the physician is entitled to fair compensation for his or her services. A physician should not charge a markup, commission, or profit on the services rendered by others. A markup is an excessive charge that exploits patients if it is nothing more than a tacked-on amount for a service already provided and accounted for by the laboratory. A physician may make an acquisition charge or processing charge. The patient should be notified of any such charge in advance. (I, II, III, IV, V) Issued prior to April 1977; Updated June 1994.

140.977 Do Not Resuscitate

HD 10/4/2008

MAG encourages hospital medical staff and governing bodies to develop and implement their own "Do Not Resuscitate" policies consistent with Georgia law and their respective bylaws, rules and regulations. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

140.980 Physician Self-Referrals

HD 10/4/2008

MAG opposes any law or practice which prohibits facilities of strictly diagnostic purposes from accepting referrals from physicians with whom they are employed. (Special Report 05.08, attachment III; Reaffirmed 10/20/2013; 10/20/2018)

140.981 Advanced Directives -- National Directory

BD 4/19/2008

MAG supports a National Government Directory of Advance Care Directives for individuals, coordinated

with a onetime tax credit of $300 for the patient, which can be easily accessed by all physicians and hospitals when the need arises. (Res. 211-07, Resolve 3; Reaffirmed 10/20/2013; 10/20/2018)

140.984 Capital Punishment (Death Penalty)

HD 4/1/1983

The participation of physicians in the implementation of the death penalty, particularly by the method of lethal injection, should not be required by the State of Georgia, inasmuch as a physician's primary responsibility is to sustain and prolong life. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

140.986 Declaration of Professional Responsibility

EC 4/7/2002

MAG adopts the following Declaration of Professional Responsibility policy:

DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well-being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and wellbeing of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to:

(1) Respect human life and the dignity of every individual.
(2) Refrain from supporting or committing crimes against humanity and condemn any such acts.
(3) Treat the sick and injured with competence and compassion and without prejudice.
(4) Apply our knowledge and skills when needed, though doing so may put us at risk.
(5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others.
(6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being.
(7) Educate the public about present and future threats to the health of humanity.
(8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being.
(9) Teach and mentor those who follow us for they are the future of our caring profession.
We make these promises solemnly, freely, and upon our personal and professional honor.
(Reaffirmed 10/13/2007; 10/20/12; 10/21/2017)

140.990 Gifts to Physicians/ Family Members
HD 4/1/1994
MAG confirms that the voluntary professional courtesy of treating colleagues and their families is part of the Hippocratic tradition, and therefore, an ethical practice which has bound practitioners since time immemorial, and which may contribute to the preservation of the integrity of the profession; further, that free drug samples and other inexpensive gifts, given to physicians by pharmaceutical or other medical industries, or the sponsorship of events that promote medical education (and thereby, enhance medical practice and the well-being of our patients) by those entities, should not of themselves be considered unethical; that the acceptance of pharmaceutical or small gift items from the pharmaceutical industry, or their use by physicians (and their families) not be considered by themselves "impermissible gifts", unless there is clear and convincing evidence to the contrary (i.e., pattern of substance abuse, etc.) --for there are not historical precedents to bolster such "ethical" pronouncements. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013,10/20/2018

140.991 Dignity of Human Life
HD 4/1/1993
MAG encourages physicians to affirm the dignity of human life by employing available pain relief, providing human companionship and giving opportunity for spiritual support and counseling in easing the suffering of their patients. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

140.999 Testing for Inherited Diseases
BD 1/1/1983
Testing for an inherited disease whose sole or principal means of prevention is control of human reproduction shall not be mandated by the State; Testing for an inherited disease shall not be mandated by the State unless mortality or irreversible morbidity can be prevented by administration of an effective treatment, the need for which is indicated by the test result in the asymptomatic patient; Testing shall not be mandated by the State for the sole purpose of detecting each and every individual who may carry or may have an inherited disease without consideration of the health care resources consumed thereby; Testing for an inherited disease shall be implemented in a way which retains the benefits resulting from the physician-patient relationship. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

145
Firearms: Safety and Regulation

145.998 Safe Storage of Firearms
HD 4/1/1992
MAG endorses the concept of safe storage of firearms in an attempt to protect children and other innocent persons from the irresponsible actions of others. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 0/20/2018)

150
Foods and Nutrition

150.997 Health Outcomes -- FNS Intervention
HD 10/18/2015

MAG supports legislation that include medically tailored Food and Nutrition Services for individuals living with severe illnesses for which there is disease-specific evidence that demonstrates the cost effectiveness and improved health outcomes that result from FNS as an intervention. (Res. 309C.15, Resolve 2)

150.998 Community Service -- Intervention
HD 10/18/2015
MAG supports the Food and Nutrition Service (FNS) agencies that provide a vital service in the community by providing high quality, low cost health intervention. (Res. 309C.15, Resolve 1)

150.999 Healthy Lifestyles
HD 10/21/2012
MAG supports expansion in public institutions such as hospitals, schools and government, to include choices in healthy food and beverages either sold or served. (Res. 109A.12; Reaffirmed 10/21/2017)

155
Health Care Costs

155.975 Tobacco -- State Excise Tax
HD 10/18/2015
MAG supports legislation that increases the state's tobacco excise tax to an amount which will improve the health of Georgia residents. (Res. 310C.15)

155.976 Tobacco Tax
HD 10/21/2012
MAG supports alternate revenue sources to offset the cost of state provided health care services including a $1 per pack increase in tobacco taxes. (Res. 308C.12; Reaffirmed 10/21/2017)

155.977 Taxes on Physician Services
HD 10/21/2012
MAG opposes taxes levied on physicians as a solution to state budget deficits. (Res. 308C.12; Reaffirmed 10/21/2017)

155.978 Obesity Education
BD 4/16/2011
MAG supports comprehensive education on the epidemic of obesity and its impact on the future health and economics of the state; furthermore MAG supports appropriate compensated payments to physicians from third party payers in Georgia in the treatment of obesity in children. (Reaffirmed 10/15/2016)

155.997 Translators
HD 10/13/2007
MAG should work with the appropriate government agency to eliminate the burden of payment by physicians for translations services and other barriers to medical care. (Resolution 113A.07; (Reaffirmed 10/20/12; 10/21/2017)

160
Health Care Delivery

160.973 New Patient Evaluations
HD 10/21/2018
MAG believes that the best practice of patient care continues to be the responsibility of the physicians to develop the diagnosis and treatment in the new evaluation of a patient, while recognizing that under limited circumstances initial evaluation may be accomplished by the advanced practitioner. (Resolution. 104A.18)

160.974 Physician Permission
HD 10/21/2012
MAG opposes rescheduling studies and procedures by insurance companies without the knowledge and permission of the original ordering physician (Res. 102A.12; Reaffirmed 10/21/2017)

160.975 Patients Treatment Decisions
HD 10/18/2015
MAG believes that insurers and payers should eliminate complex barriers and reinstate physicians as the primary authorities for patient treatment decisions including providing coverage transparency and protecting patient access to timely, affordable and medically appropriate care in Georgia. (Res.307C.15)

160.976 Withholding Care For Profit
HD 10/18/2014
MAG shall not become involved in any medical care system in which the withholding of necessary care from a patient will increase the physicians' profits. (Special Report 4, Attachment III) (Reaffirmed 10/20/2019)

160.977 Cosmetic Energy Device
HD 10/20/2013
MAG believes that the definition of the practice of medicine be clarified to include that the use of lasers, pulsed light devices, or any energy source, chemical or other modality that affects living issue (when referring to the skin, anything below the stratum corneum), for cosmetic purposes. (Res. 316.C.13; Reaffirmed 10/20/2018)

160.978 Vulnerable Patient Care
HD 10/20/2013
MAG promotes access to appropriate care for all patients, promote special access for vulnerable patients if care cannot be provided within a patient's insurance provider; and rejects any model, public or private, that restricts access to physicians and other health care professionals adequately experienced in their disease. (Res. 312C.13; 10/20/2018)

160.979 Pay-For-Performance
HD 10/21/2012
MAG encourages the use of physician data, including physician "pay-for-performance" data to: 1) benefit both patients and physicians, and to improve the quality of patient care and the efficient use of resources in the delivery of health care services; 2) when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care; and 3) when used to provide accurate

physician performance assessments in concert with AMA's Principles for Pay-for- Performance programs. (Res. 115A.12; Reaffirmed 10/21/2017)

160.980 Indigent Care

HD 10/17/2009

MAG affirms its long-standing commitment to assure all citizens' access to quality medical care, regardless of their ability to pay. MAG urges physicians to continue to provide medical care for indigent patients in order that no patient be deprived of medical care because of his/her inability to pay for it. MAG supports the expansion of the State Medicaid Program's adequate coverage of the indigent population. MAG encourages the expansion of participation by physicians in public health clinics, food kitchens for the poor, services to street people, to needy refugees, farmers, and other groups who fall between the cracks of government-funded medical assistance programs. (Special Report, Appendix III; Reaffirmed 10/2014; 10/20/19)

160.981 Medical Home

HD 10/17/2009

MAG supports the concept of the Medical Home that is consistent with the AMA's Joint Principles of the patient-centered medical home. (Officer 1, Rec. 4; Reaffirmed 10/2014; 10/20/19)

160.982 Holistic Medicine

HD 10/17/2009

Holistic medicine should be regarded as a philosophy rather than a science. MAG does not endorse holistic practices which lack clinical substantiation but are commercially marketed and objects strongly to the implication that good health will result from employment of a specific ideology or practice. MAG believes that holistic health centers or clinics should have accountability to licensed physicians and licensed or certified health personnel. The public is encouraged to examine each such center or clinic on its own merits, judging its capability to deliver appropriate health care. MAG affirms the principle that the practice of medicine traditionally addresses the physical, mental and spiritual welfare of the patient. Physicians should continue to stress the patient's self-responsibility for health and to advise the patient on the importance of nutritional awareness, physical fitness and stress management. (Special Report, Appendix III; Reaffirmed 10/20/19; 10/20/19)

160.983 Freedom of Choice

HD 10/17/2009

MAG recognizes the freedom and right of patients to choose their doctors and the right of doctors to choose their patients, true emergency excepted, should be recognized. MAG also supports the patient's right of freedom of choice of method of payment. MAG is philosophically opposed to federal and state support of any one type of health care delivery system preferentially over another. (Special Report, Appendix III; Reaffirmed 10/2014; 10/20/19)

160.984 Neurophysiological Testing

HD 10/5/2008

MAG believes that Neurophysiologic testing, including evoked potentials, intraoperative monitoring, nerve condition studies should be performed by a licensed physician or under the direct supervision of a Georgia physician and that electromyography should only be performed by a Georgia licensed physician. Neurophysiological tests shall be interpreted only by a licensed physician. (Res.101A.08; Reaffirmed 10/20/2013;10/20/2018)

160.985 Access to Care

HD 10/13/2007

MAG encourages its members to provide medical services to active duty military families as much as feasible. (Res. 101A.07) (Reaffirmed 10/20/12; 10/21/2017)

160.986 Physician-specific Data

HD 10/13/2007

MAG supports the position that any physician-specific data which is published by health plans or other entities be limited to appropriate data concerning quality of medical care, access to care, and cost of care that is based on a full and complete understanding of the patient's clinical record, their full diagnostic profile, their medical history, age and geographic and social history; and MAG opposes the publication of physician-specific data that do not meet these criteria. (Res. 106A.07) (Reaffirmed 10/20/12; 10/21/2017)

160.988 Fee for Service

HD 4/1/1994

MAG favors a pluralistic health care delivery system, which includes fee-for-service medicine. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018

160.990 Freedom of Choice

HD 4/1/1994

MAG supports patients' free choice of their physician, be they generalist or specialist. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

160.991 Freedom of Choice -- Nursing Home Patients

HD 4/1/1993

MAG supports freedom of choice for patients residing in nursing homes to select their own physician. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

160.992 Medical Care for the Disadvantaged

HD 4/1/1988

MAG encourages its members to continue their commitment to caring for all patients regardless of their ability to pay. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/20/2019)

160.993 National Health Care

HD 4/1/1988

MAG opposes nationalization of the health care delivery system. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

160.994 Alternative Delivery System Advantages

HD 4/1/1987

MAG vigorously opposes any legislation that would give alternative health care delivery systems statutory advantage over the traditional private practice of medicine. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

160.996 Private Practice of Medicine -- Definition

HD 4/1/1985

MAG defines the private practice of medicine as the delivery of medical care which is carried out in a

direct personal relationship in which direct responsibility for care and payment exists between the patient and physician. MAG supports an environment which allows for freedom of choice for both the patient and physician in selecting the location of the delivery of care, alternatives of treatment and the methods of payment for services rendered. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

160.999 Rural Health Clinics

HD 4/1/1983

MAG supports rural health clinics provided they are under the direct supervision of a physician. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

165
Health System Reform

165.966 Principles of Health Care

HD 10/17/2015

Physicians are united in our efforts to preserve our profession, as well as to promote and protect the patient-physician relationship. MAG believes that health care reform in American is founded on three core principles: 1) The right of patients and physicians to privately contract without third party interference or penalty is a touchstone of American freedom and liberty and is integral to the patient physician relationship; 2) Patients are best served when the determination of quality of medical care is made by the profession of medicine—not by the government or other third party payers; 3) Enacting medical liability reform based on proven policies is essential if we hope to restrain rising costs without restricting our patients' access to quality health care. We believe that the health reform law enacted in 2010 fails to adhere to these fundamental principles, despite the fact that they may significantly lower our federal government's expenditures for medical care. As one considers the financial "costs" of the new health reform law, one must also consider the "costs" to patients in terms of their access to care and the quality of care they can expect to receive in the future; In addition to the several positive elements of the Patient Protection and Affordable Care Act that we support-expanded health insurance coverage, insurance market reforms, coverage for prevention and wellness initiatives--we believe that the following elements are essential to arriving at an acceptable form of health care reform legislation and should replace all other provisions: 1) In general, the U.S. health care system should be based on principles which support a private, free market economic system without mandatory participation by government. Funding for expanded government health care (i.e., Medicaid) should only occur based on a sound, financially stable and sustainable funding source which is not based on reductions in Medicare or other programs or further contributes to the U.S. National Debt; 2) The replacement of Medicare's sustainable growth rate (SGR) should be monitored for appropriate criteria for quality care; 3) Proven medical liability reform measures should be constitutionally protected, including a cap on non-economic damages; 4) Anti-trust relief, which allow independent groups of physicians to collaborate on cost, quality, care coordination, and other ways to improve their practices, should be enacted; 5) Employers should not be required to provide health insurance, but should do so voluntarily; 6) Medicare, Medicaid and other payment advisory boards should not be given unprecedented authority to make sweeping changes; such changes should be decided by Congress only; 7)Patients should have the right to choose their physician; 8) Patients should have the right to choose their own form of health insurance; 9) All quality determinations which are made of medical care should be made by physicians; 10) Physician should have the right to have ownership in a specialty hospital, as long as it is fully disclosed to patients or other effected people; 11) Medicaid's eligibility requirements should not be open to additional categories of recipients unless the federal government can do so with a balanced budget;

the fee schedule is calibrated to \the actual cost of care; and the additional cost does not add to the national debt; 12) Employees should be allowed the same tax deduction for health insurance premiums as their employers; 13) The method of including consumer co-payments as a part of health insurance coverage should be continued in order to allow some level of responsibility to the consumer; 14) The government should consider the use of tax-free vouchers as a method of payment for the indigent; 15) The government should consider allowing “Means Testing” as a method for determining Medicare patient coverage or use of a stratified tax deduction/voucher system for the elderly population, in place of Medicare; 16) All patients, regardless of the presence of any third party payer, including Medicare recipients, should be able to privately contract with their doctor for medical care, without penalty to either party; 17) Physicians should be allowed to participate in health plan quality reporting mechanisms, including Medicare and Medicaid, voluntarily, without penalty; 18) Health plans, including government health plans should be allowed to establish quality/cost payment bonuses for physicians, without penalty to other participating physicians; 19) Health plans should eliminate the use of physician performance and “Profiling Episode Grouper” systems and other public reporting of physicians’ claims data, as they are presently designed, due to their widespread inaccuracies and lack of scientific validity; 20) Federal payment system reform pilot projects should include strong representation from the private physician community and include direct Congressional oversight; 21) The federal government and private health plans should narrow the scope of their audit and payment recoupment programs to true fraud and abuse violators, not to personnel committing innocent administrative errors; 22) Government and other Relative Value Current Procedural Terminology (CPT) Coding system committees should be predominately composed of private practice physicians, who most often perform those procedures, i.e., members of organized medicine and medical specialty societies. (Special Report 04.15, Appendix III)

165.969 Physicians Prescription for Georgia

HD 10/20/2013

MAG supports the Principles outlined in "MAG Physicians Prescription for Georgia": MAG supports the following core principles: 1) All Georgians should have health coverage; 2) All Georgians should have the freedom to choose their physicians and place of treatment; 3) Medical care should be cost-effective and affordable; 4) Medical care should be appropriate and of high quality; 5) Physicians, as well as all persons involved in the delivery of health care, should practice in accordance with the highest ethical standards and participate in continuous education and professional development; 6) Individuals, through their personal health habits and health care decisions, share in the responsibility for their health and well-being; and 7) Health care decisions should be based on concern for the individual, and patients should be treated with dignity, compassion, and respect.

Health System Changes

A) Quality Health Care: 1) MAG believes that physicians must have control over the use of practice parameters as guidelines to improve the quality of medical care provided in our state. Furthermore, there should be a central physician coordinating body with statutory responsibility for use of practice parameters. MAG should be given this statutory responsibility as the exclusive coordinating body to review, endorse and promote the use of practice parameters, which should be developed by medical specialty societies. MAG's responsibility would also include review and endorsement of practice parameters developed by non-physician entities, after such parameters are first reviewed and approved by the appropriate medical specialty societies. 2) Physicians whose practice is determined to not meet accepted standards of care should be required to participate in the Medical Association of Georgia's approved programs. 3) Quality assurance and cost analysis data should be collected and analyzed in a responsible manner. When used appropriately, these data can help health care providers improve the quality and affordability of health care. Raw data on the delivery or cost of medical care should be reviewed and analyzed by the physicians and data analysts to assure these data are medically and scientifically correct before being released to the public. 4) MAG strongly opposes state and/or national

"global budgeting" which arbitrarily limits, and ultimately negatively affects, the overall quality of our health care. 5) The Georgia Composite Medical Board should remain as an independent Board. This Board then will be able to devote its full attention to monitoring and investigating the practice of medicine in Georgia. 6) The medical profession should be empowered to enforce ethical and clinical standards (self-policing) through relief from current federal antitrust laws.

B) Health Insurance Coverage: 1) All Georgians should have health coverage that gives them the unrestricted freedom to choose the physician of their choice, to choose the place of treatment of their choice, and to choose the payment mechanism of their choice. Any qualified physician who is willing to participate in a particular network must be given the right to join that network; otherwise freedom of choice for patients will be lost. 2) All Georgians should have access to an essential benefits insurance plan. 3) All Georgians should have access to insurance coverage that is portable and offered without regard to preexisting conditions, prior medical family history, or previous claims experience. 4) Tax incentives should be provided by both the state and the federal governments to adequately encourage all employers and individuals to purchase health insurance. 5) MAG opposes any rules, regulations, or taxation that discriminate against or favor a particular type of insurance plan. 6) Development of health plans should not be limited to insurance companies. 7) A state small group market plan should be developed to allow small businesses access to affordable coverage for their employees. 8) All Georgians should have access to catastrophic health insurance coverage. 9) Individuals should assume a fair share of the costs for their health coverage and their medical care by paying part of the premiums, deductibles and reasonable co-payments for basic care. 10) The Insurance Industry should adopt a simplified and standardized method of claims processing. 11) The existing utilization review system should be eliminated or drastically changed. 12) Federal ERISA and similar laws must be amended to give the states more control over the insurance provided to its citizens.

C. Antitrust relief is needed so physicians can unite to negotiate without the threat of antitrust liability: 1. Antitrust relief should also allow hospitals and other facilities to negotiate with each other to facilitate appropriate allocation of resources and technology.

D. Tort Reform: 1. Reinstate the "collateral source rule." 2. Redefine the statutory definition of "standard of care." 3. Redefine "expert witness" qualifications. 4. Support and encourage the development of alternative dispute resolution pilot projects. 5. Restrict the "dismissal rule." 6. Enact a $250,000 cap on non-economic damages. 7. Expedite the timeliness with which medical malpractice cases are handled. 8. Require periodic payment of future costs.

E. The Role of State: 1. Georgia's Public Health System must be improved. MAG supports the Department of Public Health as a separate independent department headed by a physician. 2. Community-based planning should be implemented across the state. 3. A comprehensive, age- appropriate health education curriculum should be implemented for Georgia schools. 4. The Department of Community Health should make changes in the Medicaid system. 5. MAG also recommends that state and community health planning efforts address a number of proposals that could have a positive impact on access to health care for the undeserved. 6. Medical schools and residency programs should increase their emphasis on training primary care specialties. 7. Reimbursement levels for primary and preventative care should be increased to encourage physicians to enter primary care specialties. 8. Midlevel health care providers, properly supervised by physicians, should be used to improve the delivery of health care, within their scopes of practice. 9. Telecommunications and alternative delivery systems to improve the delivery of health care should be further studied. 10. Through the community planning process, transportation should be made available to those patients who have no way to get to their physicians or other health care providers. 11. Additional taxes should be imposed on the sale of alcohol and tobacco to encourage healthy lifestyles to help fund care for indigent patients.

F. The Role of the individual: 1. Have a personal physician and work with the doctor to maintain your health. 2. Check fees and prices in advance. 3. Use second opinions wisely. 4. Practice "personal cost containment." 5. Play a role in addressing the societal problems that have an impact on health care costs. 6. Maintain as healthy a lifestyle as possible. 7. Authorize a durable power of attorney for healthcare or sign a living will. 8. Know your rights: --The patient has the right to eceive information from physicians and to discuss the benefits, risks and costs of other appropriate treatments --The patient has the right to make decisions regarding the health care that is recommended for their medical treatment --The patient has the right to confidentiality --The patient and physicians share the goal of ensuring all have available adequate health --The patient has a right to choose his or her own physician. (Committee 04.13, Attachment III; Reaffirmed 10/20/2018)

165.970 Principles of Health System Reform

HD 10/20/2013

MAG endorses the following Core Principles on Health System Reform: 1) All Americans should have defined health care coverage that includes access to a fully licensed physician (MD/DO) when such persons believe that they have a health problem; 2) Universal access to health care should be provided through a private sector/public sector partnership that builds upon the strengths of our current health care system; 3) Government programs should enhance our current employment- based system and provide coverage or assistance to those outside that system who are unable to provide coverage for themselves and their families; 4) 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; 5) 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 individuals prior to their selection of that system; 6) Physicians' clinical judgments should be subject to professional peer review to maintain and enhance the quality of care delivered to patients. When in conformance with standards and practice parameters developed by and acceptable to the profession, such clinical judgments should not be subject to third party payer challenges. Medical societies should be empowered to operate programs for the review of patient complaints about fees, services, etc.; 7) A pluralistic delivery system is essential. Such a system should be enhanced through governmental action to apply the same rules of competition to all competitors, including insurance carriers and self-insureds; 8) Physicians should retain the freedom to choose their method of earning a living (fee-for-service, salary, capitation, etc.); 9) Physicians should retain the right to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; 10) Health insurance market reform is essential, particularly for the small business market, and community rating, elimination of pre-existing conditions, guaranteed renewability, limits on premium increases, portability, and continuity are critical elements to assuring universal coverage; 11) MAG should achieve the right to negotiate for physicians' program payment and the other conditions in government health entitlement programs, where legislation and/or administrative restrictions are unilaterally applied to physicians' freedom to set their own fees. Any such fee restrictions should be limited to those patients who cannot reasonably afford to pay the difference between the physician fees and government reimbursement levels. In the private sector, where insurance arrangements for thousands of patients are increasingly controlled by single third party payers, physicians should have the ability to negotiate collectively on behalf of their patients and themselves; 12) Single-payer systems are not in the best

interest of the public, physicians or the health care of this nation and should be strenuously resisted. (Special Report 04/13, Attachment III); HOD referral to Board; Board Reaffirmed 5/4/2019

165.971 State Directed Health Care

HD 10/16/2011

MAG favors health care reform that is flexible and with specific implementation primarily determined by the states on an individual basis. (Res. 304C.11) (Reaffirmed 10/15/2016)

165.972 Accountable Care Organizations

BD 1/29/2011

The following ACO principles shall be guiding principles for Georgia physicians when negotiating ACO contracts for the medical practice. (Reaffirmed 10/15/2016)

1. Guiding Principle – The goal of an Accountable Care Organization (ACO) is to increase access to care, improve the quality of care, and ensure the efficient delivery of care. Within an ACO, a physician's primary ethical and professional obligation is the well-being and safety of the patient.
2. ACO Governance – ACOs must be physician-led and encourage an environment of collaboration among physicians. ACOs must be physician-led to ensure that a physician's medical decisions are not based on commercial interests, but rather on professional medical judgment that puts patients' interests first. a. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians to ensure that medical decisions are made by physicians (rather than lay entities) and place patients' interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity. MAG supports true collaborative efforts between physicians, hospitals, and other qualified providers to form ACOs as long as the governance of those arrangements ensures that physicians control medical issues. b. The ACO should be governed by a board of directors that is elected by the ACO professionals. Any physician entity [e.g., Independent Physician Association (IPA), medical group, etc.] that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors. c. The ACO's physician leaders should be licensed in the state in which the ACO operates and in the active practice of medicine in the ACO's service area. d. Where a hospital is part of an ACO, the governing board of the ACO should be separate and independent from the hospital governing board.
3. Physician and patient participation in an ACO should be voluntary. Patient participation in an ACO should be voluntary rather than a mandatory assignment to an ACO by Medicare. Any physician organization (including an organization that bills on behalf of physicians under a single tax identification number) or any other entity that creates an ACO must obtain the written, affirmative consent of each physician to participate in the ACO. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid or a private payer, or being admitted to a hospital medical staff.
4. The savings and revenues of an ACO should be retained for patient care services and distributed to the ACO participants.
5. Flexibility in patient referral and antitrust laws — The federal and state anti-kickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs. This is particularly important for physicians in small and medium-sized practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The ACA explicitly authorizes the Secretary to waive requirements under the Civil Monetary Penalties statute, the Anti-Kickback statute, and the Ethics in Patient Referrals (Stark) law. The Secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as ACOs. In addition, the

Secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants. Physicians cannot completely transform their practices only for their Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS, so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
6. Additional resources should be provided up front in order to encourage ACO development. The CMS Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group's risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the "shared savings" model only provides for potential savings at the back end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).
7. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk-adjusted for individual patient risk factors. a. The ACO spending benchmark, which will be based on historical spending patterns in the ACO's service area and negotiated between Medicare and the ACO, must be risk-adjusted in order to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill. b. The ACO benchmark should be risk-adjusted for the socioeconomic and health status of the patients who are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race and ethnicity, and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility. c. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating cost factors (i.e., hospital wage index), and physician HIT costs.

165.974 Health Care Access

HD 10/17/2009

The Medical Association of Georgia, through lobbying activities and through grassroots membership advocacy activities at the local, state and national levels, shall promote health care reform that supports expansion of health care access for our patients. (Res. 602HSR.09; Reaffirmed 10/2014; 10/20/19)

165.975 Medical Home

HD 10/17/2009

The Medical Association of Georgia, through lobbying activities and through grassroots membership advocacy activities at the local, state and national levels, shall promote health care reform that supports patient-centeredness by expansion of pilot projects for the Patient-Centered Medical Home. (Res. 602HSR.09; Reaffirmed 10/2014; 10/2019)

165.976 Payment System Reform

HD 10/17/2009

The Medical Association of Georgia, through lobbying activities at the local, state and national levels, shall promote health care reform that supports the revitalization of primary care via payment system reform and workforce augmentations. (Res. 602HSR.09; Reaffirmed 10/2014; 10/2019)

165.977 Health Care Benefits to Undocumented Immigrants

HD 10/17/2009

MAG opposes legislation that would allow individuals that are not lawfully in the United States to obtain health care benefits funded in whole or in part by the U.S. government. (Officer 1.09, Rec 13; Reaffirmed 10/2014; 10/2019)

165.978 Individual Health Insurance Mandate

HD 10/17/2009

MAG opposes any statutory imposed mandate that individuals secure health insurance. (Officer 1.09, Rec. 12; Reaffirmed 10/2014; 10/2019)

165.979 Employer Health Insurance Mandate

HD 10/17/2009

MAG opposes any statutory mandate that employers provide health insurance benefits to their employees. (Officer 1.09, Rec. 11; Reaffirmed 10/2014; 10/2019)

165.982 Health Insurance Tax Credit

HD 10/17/2009

MAG supports an individual's right to purchase health insurance with tax-free dollars regardless of their employment status. (Officer 1.09, Rec. 5; Reaffirmed 10/2014; 10/2019)

165.983 Right to Privately Contract

HD 10/17/2009

MAG supports the rights of patients and physicians to privately contract for medical care in any situation, without penalty, regardless of the existence of third party payers. (Officer 1.09, Rec. 2; Reaffirmed 10/2014; 10/2019)

165.984 Individual Insurance Ownership

HD 10/17/2009

MAG supports health care reform legislation that promotes individual ownership of health insurance policies. (Officer 1.09, Rec. 1; Reaffirmed 10/2014; 10/2019)

165.985 Patient-/Physician Relations

HD 10/17/2009

MAG opposes laws and regulations which work to the detriment of good patient-physician relations and services. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

165.987 Tax Reform

HD 5/1/1999

MAG supports the AMA's continued monitoring and study of the impact of the various tax reforms on the U.S. health care delivery system and urges that the AMA continue to inform AMA members and the public about the impact of such tax reforms, Res. 310C-99 (Reaffirmed 10/2005;10/16/2010; 10/17/2015)

165.997 Litigation Costs Reduction

HD 4/1/1993

MAG supports legislation which includes litigation cost reductions in any discussion of health care reform. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

170
Health Education

170.988 Stigma on Obesity
HD 10/21/2018
MAG supports eliminating the stigma on obesity. (Res. 302C.18)

170.989 STD Education for Physicians
HD 10/16/2011
MAG supports improvements in training and education on STDs for physicians and urges medical schools to provide supervised training on STDs for all medical students and physicians in training. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

170.991 Programs and Forums
HD 10/4/2008
MAG encourages local school systems to develop health education programs and to consider the promotion of health forums, media presentations and other means of disseminating health information to the public. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

170.992 Sex Education Materials
HD 10/4/2008
MAG opposes legislation that would weaken sexual education in schools and supports continued study be done on any and all materials of this nature to ensure that Georgia physicians are looking at this subject carefully for the benefit of concerned patients. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

170.993 Sex Education -- Public Schools
HD 10/4/2008
MAG supports efforts to enhance the effectiveness of sexual education in Georgia's schools, and MAG opposes legislation which would, if adopted, effectively eliminate any sexual education from being provided. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

170.996 Sex Education Programs
HD 4/1/1993
MAG encourages the school systems (public and private) in Georgia to institute programs for sexual education and counseling to assist Georgia's students. MAG supports education which promotes sexual abstinence as a safe lifestyle while providing information on condoms and sexual activity as a secondary emphasis. When condom usage is taught, proper technique and the full disclosure of condom failure, including causes and rates, and possibly resultant STDs, including AIDS, should also be conveyed. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

180
Health Insurance

180.972 Patient ID Card

HD 10/17/2015
MAG supports requiring all health insurers to provide basic information on the insured's identification card including, but not limited to, patient name, patient identification number, group number, name of insurer, type of plan (this should be well defined and accurate and include if it is an Exchange or ERISA plan)), effective date of coverage, copayments and deductibles, central labs, restrictions, such as no coverage for wellness checkups or immunizations, insurance company telephone number and claims address. Include dependent names and pharmacy contact. (Special 04.15 Appendix III)

180.973 Health Insurance --Tax Credit

HD 10/18/2014
MAG supports legislation that provides tax credits and deductions to all, and subsidies to those who cannot afford to purchase their own health insurance, as a means of promoting individual ownership of private health insurance. (Special Report 4, Attachment III). (Reaffirmed 10/2019)

180.974 Patient Insurance Benefits

HD 10/21/2012
MAG supports requiring insurance companies to provide to physicians and hospitals at the time of a patient treatment the following: 1) co-pay and deductibles; 2) any preventive care services not subject to a co-pay or deductible; 3) the patient's accurate formulary and benefit information for pharmacy benefits; 4) the amount the patient owes at the time of service; and 5) accurate information about the amount owed by the insurance company to physicians and hospitals at the time the service is provided. (Res. 102A.12; Reaffirmed 10/21/2017)

180.975 Health Plan Formulary

HD 10/17/2009
MAG supports drug formularies that are based on best clinical and scientific evidence. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

180.976 Health -- Individual Retirement Accounts (IRAs)

HD 10/17/2009
MAG will pursue activities to inform physicians and the public about the value and availability of Health Savings Accounts. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

180.977 Health Insurance Provision

HD 10/17/2009
MAG encourages employers to make health insurance available for all employees. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

180.979 Credentialing Fees

HD 8/22/2003
The Medical Association of Georgia opposes insurance companies charging health care providers to be credentialed both initially and upon renewal. (Res. 307C-03) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

180.980 ERISA

BD 8/1/2000
MAG supports the revision of ERISA laws so as to make self-insured plans subject to state regulations. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

180.981 Credentialing

HD 5/1/2000

MAG believes that health insurers should be required to expedite the credentialing process for all physicians and that it should be no more than thirty days for any physician who changes practice locations within the State of Georgia and is already credentialed by the insurer as a panel physician, Res. 304C-00 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

180.982 Patient's Right to Privacy

HD 10/16/2010

MAG opposes the disclosure of patient-specific illness information to an employer unless the patient clearly understands the medical information to be released and consents to such disclosure in writing, Special Report 04.10, III (Reaffirmed 10/17/2015)

180.984 Prompt pay

HD 5/1/1998

MAG supports aggressively seeking enforcement of the current law requiring insurers to promptly reimburse physicians for health care services. Officer: 1-98, Rec. 5 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

180.985 Health Insurance Tax Preference

HD 4/1/1996

MAG supports legislation that gives individuals the same tax preference as job-based health insurance when individuals purchase their own insurance plans. (Reaffirmed 05/2002; 10/2/07; 10/20/12; 10/21/2017)

180.986 Tax Equity

HD 5/1/1995

MAG supports tax equity of employer-based medical insurance, individual-paid medical insurance, un-reimbursed out-of-pocket medical care, and individual medical savings accounts. (Reaffirmed by the Board of Directors on 4/14/07) (Reaffirmed 10/20/12; 10/21/2017)

180.987 Medical Savings Accounts

HD 5/1/1995

MAG supports medical savings accounts combined with catastrophic insurance, as a cost efficient alternative to managed care. MAG supports a state tax code exemption for MSAs and exemption with the United States tax code to allow for MSA exemption. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

180.988 Single Payer System -- Employer Mandate

EC 8/1/1994

MAG opposes any single payer system including any that would require an employer mandate. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

180.992 Patients' Rights -- Health Insurance

HD 4/1/1987

MAG supports legislation protecting patients' rights by limiting an insurer's ability to alter contracts with physicians and/or patients without appropriate safeguards to preserve the quality of care delivered. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

180.993 Preadmission Certification -- Administrative Services

HD 4/1/1986

Preadmission requests by third party payers is a service by physicians to third party payers which is unrelated to patient service; consequently, third party payers are obligated to pay separately for these services. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

180.996 Alternative Payment Mechanisms

HD 4/1/1984

MAG supports the development of alternative mechanisms of payment for care that increase patient awareness and involvement in the reimbursement process. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

180.998 Utilization Review Mechanisms

HD 4/1/1983

MAG supports the concept that every hospital medical staff should have a viable, active and effective utilization review mechanism, recognizing that specific needs will vary from place to place, and that in some instances, combined or joint efforts by smaller facilities may be necessary in order to provide utilization review of an acceptable quality. MAG agrees strongly that true utilization review by physicians should be done only to determine the appropriateness and quality of care rendered. it should never be performed as fiscal review. MAG does not believe that physicians performing medical services should be required to perform utilization review simply to aid a facility insurer or other third party to reduce their operating costs. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

180.999 National Health Insurance

HD 4/1/1976

MAG takes a firm stand against government-sponsored national health insurance for all individuals. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; BOD 5/4/19)

185
Health Insurance: Benefits and Coverage

185.960 Prior Approval -- Insurance Payment

HD 10/20/2019

MAG believes that because obtaining prior authorization goes beyond the medical standard of care, insurance companies should pay physicians for the extra time in performing these relevant administrative activities. (Res. 101A.19)

185.961 Colonoscopies -- Medicare

HD 10/22/2017

MAG shall advocate that insurance companies offering Medicare Advantage product lines in the state of Georgia to: 1) voluntarily waive co-pays for polyp removal discovered during a colonoscopy screening by reclassifying polypectomy as screening, not therapeutic, 2) voluntarily waive costs by reclassifying the biopsy test as screening not therapeutic, and 3) waive all cost-sharing associated with positive stool-tests that require a follow up colonoscopy, defining it as part of the screening continuum. (Res. 102A.17, resolve 2).

185.962 Colonoscopy Screening

HD 10/22/2017

MAG shall advocate that all commercial health insurance plans offered in the state of Georgia: 1) voluntarily waive all cost sharing associated with screening colonoscopies, and 2) re-classify that a follow-up colonoscopy as part of the screening continuum and included in the waiver. (Res. 102A -17, resolve 1)

185.963 CDC Opioid Prescription Guidelines

HD 10/16/2016

MAG opposes the use of the CDC Opioid Prescription Guidelines by third party payers as a basis for restricting or obstructing access to opioid therapy. Res. 605S.16).

185.964 Admissions -- postoperative complications

HD 10/16/2016

MAG supports legislation requiring insurance companies to defer to the surgeon regarding the need for hospitalization for postoperative complications for the first three weeks after surgery for non-neurosurgical patients and the first six weeks for neurosurgical patients...(Res. 311C.16, Resolve 2)

185.965 Admissions -- Physician Control

HD 10/16/2016

MAG believes that surgeons, not insurance companies shall determine the need for hospitalization for a post-surgical complication, for the first three weeks after surgery for non-neurosurgical patient, and the first six weeks for neurosurgical patients. (Res. 311C.16, Resolve 1)

185.966 Insurance Contracts

HD 10/16/2016

MAG supports physicians and other providers having the opportunity to discuss insurance contracts during the time of year that grants patients sufficient notice prior to open enrollment and only end coverage for the patient at the end of open enrollment. (Res. 308C.16)

185.967 Network Transparency and Management

HD 10/16/2016

MAG supports legislation that will ensure network transparency and network management to benefit patients with the following elements: 1) Providing information by insurers that allows patients and physicians to evaluate network adequacy within their hospital which will include publishing accurate and timely provider in-network ratio, and list in-network physicians by medical specialty and medical groups, and 2) Providing in a non-emergency care setting that a) patients be given statements that services may be provided by out-of-network physicians; b) hospitals post names and links of all contracted insurers for benefits of both consumers and medical staff; and c) having insurers create and support a system for network navigation to provide in-network consumer protection, and to inform consumers as to whether a physician is in-network and the consequences of using an out-of-network physician. (Res. 302C.16)

185.968 Insurance Transparency

HD 10/18/2015

MAG shall advocate for: 1) all prior approval procedures and forms to be clearly available on an insurance plan website; 2) forms to be transparent with all materials in clear, concise and literacy appropriate language for the calendar year; 3) all insurance companies to post current drug formularies clearly on an insurance plan website; and 4) provide the drug formulary when denied. (Res. 305C.15)

185.969 Opioids -- Abuse Deterrent Technology

HD 10/18/2015

MAG believes that if insurance carriers provide coverage for a certain extended-released opioid, they must also provide equitable coverage for the same extended-release opioid with abuse-deterrent technology when available. (Res. 302C.15)

185.970 Insurance Networks

HD 10/19/2014

MAG supports requirements that all health insurance plans are regulated to ensure network adequacy by requiring insurers to provide transparency regarding the methodology for physician selection in health insurance networks and sufficient quality patient access to all physician specialties. (Resolve 1, Res. 311C.14) (Reaffirmed 10/2019)

185.971 Prior Authorization

HD 10/18/2014

MAG principles on prior authorization are that:

1) Health plans, rather than physicians, should be responsible for checking its own data base of information to verify the patient's eligibility and coverage information during prior authorization; 2) Patient and health plan information website in conjunction with a request for prior authorization should be considered forever valid by the health plan for claims payment and any other audit process; 3) Health plans should only allow physicians who perform the medical service or procedure to submit the request for prior authorization; 4) Once a prior authorization request for a service or procedures is approved by the health plan, and the health plan validates the patient's eligibility and coverage, the health plan is obligated to pay for the service that's billed by the physician; 5) All managed care contracts should include the provisions that are highlighted in these principles; 6) All health plan requests for patient clinical information made in conjunction with a physician's request for prior authorization should be commensurate with the complexity of the procedure or service that's requested; 7) Health plans should provide a specific reason when they deny a medical service or procedure in response to a physician's prior authorization request; 8) Prior authorizations should not be denied for a minor or immaterial mistake on the request form (i.e., change of date of service); 9) If a medical service is urgent, a health plan should not deny payment of that service for failure of a physician to obtain a prior authorization; 10) All health plans should clearly display a complete list, by name, description and CPT code of services or procedures, which require prior authorization, that's easily obtainable by the attending physicians on its website and/or other normal methods of communication; 11) All health plans should provide a standard of acceptable prior authorization communication including contact by telephone, fax, and website; 12) Health plans should be transparent in their communication with physicians about the basis for their prior authorization program, including: (a) the specific criteria used for determining the medical necessity of the service and the accompanying administrative structure who oversees the process, i.e., national advisory boards, (b) the basis for placing a service/procedure on the prior authorization list; (c) the cost-effectiveness of the process and (d) the profits gained through denial of a PA service or procedure; 13) Health plans should eliminate the financial penalties that are levied against physicians for failing to obtain a prior authorization; 14) All health plans should have a central point for submission for all prior authorization requests, with additional options available as needed; 15) Health plans should standardize their response times to prior authorizations to between 24 to 48 hour that is obtained by a physician from the health plans; 16) Health plans should provide peer review services 24/7; 17) Peer review should consist of review by like specialty and practice setting; 18) Health plans should allow submissions of prior authorization requests without deadlines, other than that it occur before the service or procedure; 19) The list of services required for prior authorization by health plans should be reasonable, consistent among plans, and based on scientific literature which substantiates a reasonable need for the service to be

questioned; it should not be solely based on the cost of the service. (Special Report 4: Attachment III) (Reaffirmed 10/2019)

185.972 All Product Clause

HD 10/21/2012

MAG opposes "all product clauses" in health insurance contracts, and promotes legislative measures to make such practices illegal in Georgia, and excluded from any health insurance exchange product offered in the state. (Res. 301C.12; Reaffirmed 10/21/2017)

185.973 Quality Outcome Reporting

HD 10/21/2012

MAG support federal legislation to adjust criteria of quality outcome reporting to account for counseling and education provided when patient noncompliance influences outcomes. (Res. 114A.12; Reaffirmed 10/21/2017)

185.974 Hospital Readmissions

HD 10/21/2012

MAG opposes penalties levied at the state and/or federal level against physicians and hospitals for restrictions on 30-day re-admissions. (Res. 111A.12; Reaffirmed 10/21/2017)

185.975 Obesity Counseling

HD 10/21/2012

MAG supports third party payer reimbursements of anti-obesity counseling by physicians. (Res.109A.12; Reaffirmed 10/21/2017)

185.976 Clinical Care Counseling

HD 10-16-2011

MAG shall: 1) actively oppose government and/or third party payers' interference in the content of communication in the delivery of clinical care between physicians and patients and a physician's medical judgment as to the information or treatment that is in the best interest of a patient including the First Amendment right of physicians in their practice of the art and science of medicine to counsel patients on the dangers of firearms, and 2) support any litigation that may be necessary to block the implementation of newly enacted state laws restricting the privacy of the physician-patient-family relationship. (Res. 101A.11) (Reaffirmed 10/15/2016)

185.977 Pay for Performance

HD 10/15/2016

MAG encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of recourses in the delivery of health care services. While MAG respects innovations in assessing quality of care and cost efficiency, we do not believe the profiling methods that insurance companies use in their pay-for-performance programs are accurate and effective in achieving this goal. (Consent Calendar Appendix III)

185.978 Telephone Message Reimbursements

HD 10/17/2009

MAG supports third party payer reimbursement for physician services provided by electronic means. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

185.979 Health Benefits

BD 1/24/2009

MAG supports the inclusion of age and gender appropriate primary and preventative health benefits in insurance and other related legislation and supports clearly defined benefits. (Reaffirmed 10/2014; 10/2019)

185.981 Verification of Patient Denials Eligibility

HD 10/5/2008

The Medical Association of Georgia advocates for state legislation which regulates that when physicians verify that a patient is eligible prior to the provision of a medical service, a managed care health plan must not retroactively deny the service and payment. (Reaffirmed 10/21/2012; 10/21/2017)

185.983 Peach Care

HD 10/13/2007

MAG supports eligibility for the provisions of Peach Care for Children at its current threshold of 235 percent of the Federal Poverty Level. (Resolution 204B.07; Reaffirmed 10/20/12; 10/21/2017)

185.984 Indigent Care

HD 10/13/2007

MAG supports development of a statewide system for documenting uncompensated indigent care provided by physicians similar to the Health Access Initiative created by the Hall County Medical Society; and supports legislation which provides tax credits for uncompensated indigent care provided by physicians. (Resolution 201B.07, Resolves 1 & 2; Reaffirmed 10/20/12; 10/21/2017)

185.985 Deductibles

HD 10/13/2007

MAG supports legislation and/or regulatory reform that requires insurance companies to credit deductibles only after fees are paid by the patient to their physician. (Resolution 212B.07; Reaffirmed 10/2012; 10/21/2017)

185.986 Point of Service

HD 10/13/2007

MAG opposes health benefit plans that restrict access to physicians to annually offer enrollees the opportunity to obtain coverage for out-of-network services through a point of service option. (Special Committee, Appendix III; Reaffirmed 10/20/12; 10/21/2017)

185.987 Screening Coverage

HD 9/30/2006

MAG supports commercial and governmental health coverage of screening procedures, such as CBC, BMP, CMP, TSH, UA, Lipid Panel and yearly physical exams to provide for early detection and intervention for determining appropriate care. Res.211C.06; Reaffirmed 10/16/2011; 10/15/2016)

185.992 Mandated benefits

HD 5/1/1999

MAG supports mandated benefits only when they provide quality patient care, are clearly cost- effective and have strong public health benefits. Mandated benefits that relate to the length of inpatient hospital stay or similar medical decisions should be made by the treating physician according to recognized medical standards, Committee 10-99, Rec. 3 (Reaffirmed 10/2005;10/16/2010; 10/17/2015

185.994 Chlamydia Screening
EC 12/1/1997
MAG supports insurance coverage for Chlamydia screening in Georgia. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

190
Health Insurance: Claim Forms & Claims Processing

190.982 Medical Claims Review
HD 10/4/2008
MAG supports the principles that medical claim reviews should be made only by physicians who are licensed to practice medicine in the state in which the medical service is provided. In addition, the review should be made by physicians of the same or comparable specialty. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

190.983 National Provider Identification
HD 10/13/2007
The Medical Association of Georgia supports legislation that would penalize Georgia Medicaid for its failure to pay claims within 15 days and interest to physicians from the date of the original clean claim regardless of NIP-related problems. The Medical Association of Georgia supports federal legislation that reduces the compensation to Medicare carriers administering government health plans for their failure to meet the NPI deadline. Resolution 205B.07 -resolves 1-3; Reaffirmed 10/20/12; 10/21/2017)

190.984 Universal Payment Reporting Form
HD 10/13/2007
MAG supports the use of universal and uniform claims and payment reporting forms which contain the same essential information used by all payers. (Comm. 01.07, Attachment III; Reaffirmed 10/20/12; 10/21/2017

190.985 Insurance Refunds
HD 8/22/2003
The Medical Association of Georgia supports requiring insurance companies to have refund policies which have a limit equal to their limit on the timeframe physicians have to file a claim. (Resolution 309C-03) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

190.987 Insurance Downcoding and Overpayment
HD 5/19/2001
MAG supports policies, regulations, and legislation which require that post payment reviews, downcodes, and other similar demands for refunds by third party payers be made within one year of the date the claim is submitted, or within the amount of time permitted for submission of the claim, whichever is less. (Reaffirmed 9/30/2006; 10/16/2011; 10/21/2012; 10/21/2017)

190.990 Timely Submission of Claims
HD 5/1/1998

MAG supports establishing a requirement that insurance companies may not deny payment of a claim on the basis that the claim is untimely submitted, provided that the claim is submitted within one year of the date of service. (Resolution 205B-98) (Reaffirmed 10/2009; 10/2014; 10/2019)

190.996 Claims Processing and Claims Denials
HD 4/1/1989
MAG should encourage third party payers to improve timely notification regarding any and all denied claims. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

200
Health Workforce

200.994 Nurse Shortage
HD 10/21/2012
MAG supports appropriate efforts to increase the number of qualified registered nurses in Georgia. (Resolution 116A.12; Reaffirmed 10/21/2017

200.995 Government Resources for Physicians
HD 10/21/2012
MAG supports government efforts to increase financial resources and develop policies to improve the number of physicians practicing in Georgia. (Resolution 116A.12; Reaffirmed 10/21/2017)

200.996 Physician Workforce
HD 10/16/2011
MAG will regularly monitor and review data from the Georgia Board for Physician Workforce and disseminate to the membership the results of such reviews. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

200.998 Physician Placement
EC 12/1/1986
MAG supports the recruitment of fully licensed physicians for short-term, general medicine assignments at Indian Health Service and National Service Corps hospitals and clinics. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

200.999 Physician Placement
HD 4/1/1984
MAG supports computerized placement services and the recruitment efforts of the Georgia Board for Physician Workforce. (Reaffirmed 05/2000, 10/2009; 10/2014;10/2019)

205
Health Planning

205.984 Dying in America
HD 10/18/2015
MAG supports and promotes the recommendations of the Institute of Medicine (IOM) "Dying in

America" report, which provides recommendations to improve the quality of end-of-life care received by all patients. (Res. 113A.15)

205.985 POLST in Georgia

HD 10/20/2013

In regard to the use of Physician Orders for Life Sustaining Treatment (POLST), MAG supports the following:1) the use of Physicians Orders for Life Sustaining Treatment (POLST) in conjunction with advanced directives for appropriate patients; 2) through legislation or other appropriate means the transferability of POLST from facility to facility through the following: a) a physician or other medical provider such as a nurse, or EMS, or medical institution, shall respect and honor life sustaining treatment orders executed by another physician; b) there is a fundamental "duty to comply" with a patient's wishes, such that in a situation where a physician is treating a patient who has a POLST signed by a physician who does not have admitting privileges at a hospital or health care facility, this does not remove the obligation of the physician or other medical provider, such as EMS to honor the POLST order; c) the patient or patient's authorized surrogate has signed the order and offered the order in full knowledge of the order's contents and a Georgia medical license is on the order; d) a physician or other medical provider, such as a nurse or an EMS, or medical institution, shall not be subject to criminal prosecution, civil liability or professional discipline by honoring a POLST order; and 3) the education of all levels of providers regarding POLST (Physician Order for Life Sustaining Treatment) and conveys the importance of this education through supporting CME. (Res. 114A.13; Reaffirmed 10/20/2018)

205.986 Paternal Responsibility

HD 10/16/2011

MAG encourages paternal responsibility in the birth and rearing of a child. (Res. 306C.11) (Reaffirmed 10/15/2016)

205.987 End of Life

HD 10/16/2011

MAG endorses and promotes patient-physician discussions on end-of-life issues. (Res. 107A.11) (Reaffirmed 10/15/2016)

205.988 Physicians Orders -- POLST

HD 10/13/2007

MAG advocates, through appropriate agencies, that Physician Orders for Life Sustaining Treatment (POLST) be coordinated with Advance Directives and/or a Durable Power of Attorney for health care. (Resolution 211B-07; Reaffirmed 10/20/12; 10/21/2017)

205.989 Certificate of Need -Laws & Regulations

HD 10/17/2009

“It is the position of the Medical Association of Georgia that Certificate of Need is anti-competitive, restricts the development of physician-owned and operated ambulatory surgical procedure and imaging centers, laboratories, and ancillary services, and limits the ability of physicians to deliver high quality, cost-effective care to Georgia’s patients.

The Medical Association of Georgia opposes Certificate of Need and supports the repeal of Certificate of Need laws in general and specifically as they apply to physician-owned and operated outpatient diagnostic centers, imaging centers, ambulatory surgical centers, laboratories and ancillary services. The Medical Association of Georgia will endeavor to educate legislators and the business community about the policy benefits of eliminating Certificate of Need.

Until Georgia's Certificate of Need laws are repealed, the Medical Association of Georgia opposes any changes to such laws that would make it more difficult for physicians to establish and operate ambulatory surgical centers, such as making it more difficult to obtain an exemption from Certificate of Need review or decreasing the capital, equipment, single-specialty physician-owned ASC, or joint venture ASC expenditure thresholds.

With respect to exemptions from Certificate of Need review (and obtaining a Letter of Non-Reviewability), the Medical Association of Georgia supports expanding the exemption from Certificate of Need review for single-specialty physician-owned ambulatory surgical centers to multi-specialty physician-owned ambulatory surgical centers. In the alternative, the Medical Association of Georgia supports recognition as a "single-specialty", for purposes of the single-specialty exemption from Certificate of Need review (and obtaining a Letter of Non-Reviewability) for physician-owned ambulatory surgical centers, any specialty or subspecialty recognized by the American Board of Medical Specialties. The Medical Association of Georgia opposes statutory or regulatory provisions that authorize a competitor of an applicant for an exemption from Certificate of Need review (and Letter of Non-Reviewability) to challenge a determination by the Department of Health that the applicant's proposed project is exempt from Certificate of Need review.

The Medical Association of Georgia will support MAG members who seek legal remedies to Certificate of Need provisions that are unfair to physicians." (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

205.990 Advance Directives

HD 10/13/2007

MAG supports federal financial incentives through use of a one-time refundable tax credit of three hundred dollars ($300) to those individuals who prepare their Advance Directives and Durable Power of Attorney for health care decisions. (Res. 211.07, Resolve 2; Reaffirmed 10/20/12; 10/21/2017)

210
Home Health Services

210.996 Home Health Care

HD 10/18/2014

MAG supports home health care and encourages physicians to take a more active role in home health care services. (Special Report 4, Attachment III) (Reaffirmed: 10/2019)

210.998 Home Health Care -- Physician Payment

HD 4/1/1987

MAG supports development of a method (such as CPT Codes) identifying services for reimbursement of physicians who are managing the care of home bound patients through a home health care agency. (Reaffirmed 5/2000, 10/2009; 10/2014; 10/2019)

210.999 Home Health Care -- Quality Assurance

HD 4/1/1987

MAG supports the development of appropriate controls to insure the quality of home health care delivery. (Reaffirmed 5/2000, 10/2009; 10/2014; 10/2019)

215
Hospitals

215.990 Protocols
EC 1/23/2009
MAG opposes the use of registered nurse and physician assistant protocols for hospital employees in employee health clinics. (Reaffirmed 10/2014; 10/2019)

215.991 Exclusive Contracts
HD 5/4/2002
MAG is opposed to the use of exclusive contracts between insurance companies and hospitals throughout the state and supports legislation which prohibits it. (Res: 308C-02; Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

215.992 Ancillary Services Payment
HD 5/19/2001
MAG supports legislation which would prohibit a hospital from entering into a contract with an insurer that prevents payment for ancillary services to anyone except those owned or contracted by the hospital. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

215.993 Hospital Exclusive Contracts -- Forced Acceptance
HD 5/19/2001
MAG opposes any efforts which would require physicians to accept all insurance contracts accepted by the hospital in which they provide service. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

215.994 Hospital Purchases
HD 5/19/2001
MAG supports regulations and/or legislation which requires that a publicly owned hospital, with public or private administration, consult with its full medical staff sixty days prior to signing any contract containing a provision for administration of the hospital by an outside party. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

215.996 Hospitalists
HD 5/1/1999
MAG opposes the mandatory use of "hospitalists" for inpatient care, Res. 105A-99 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

215.997 Indigent Care Funding for Hospitals
HD 4/1/1989
MAG supports the State of Georgia providing financial support to all nonfederal hospitals for the purpose of the care of indigent patients. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

215.998 Transfusion Products
HD 4/1/1983
MAG supports requiring hospitals providing obstetrical services to have blood products for transfusion immediately available. (Reaffirmed 5/2000; 10/17/2009; 10/2014; 10/2019)

215.999 Hospital -- Public Training
HD 10/20/2018
MAG supports additional state participation in the funding of training programs at all public teaching hospitals in Georgia. (Special Report 3, III)

230
Hospitals: Medical Staff-Credentialing/Privileges

230.990 Maintenance of Certificate (MOC)
HD 10/16/2016
MAG supports legislation that prohibits the use of Maintenance of Certification (MOC) as a condition of medical licensure or as a prerequisite for hospital or staff privileges, employment in state medical facilities, reimbursement from third parties or insurance of malpractice insurance. (Res. 303C.16)

230.991 Board Recertification -- NBPAS
HD 10/18/2015
MAG accepts the National Board of Physicians and Surgeons (NBPAS) as an alternative to ABMS for recertification of physicians in Georgia. (Resolution 101A.15)

230.993 Emergency Department Training
HD 10/20/2012
MAG supports the American College of Emergency Physicians (ACEP) policies, (ACEP Policy Compendium, 2012 Edition) which, in part, recognizes the roles of the American Board of Emergency Medicine (ABEM) and the American Osteopathic Board of Emergency Medicine (AOBEM) to set and approve the training standards, assess competency through board certification processes and establish professional practice principles for emergency physicians. Furthermore, MAG supports ACEP's assertion that the specific process for physician credentialing and delineation of clinical privileges must be defined by hospital or organized medical staff and department bylaws, policy, rules, or regulations. These are also requirements of the Code of Federal Regulations for Hospitals and the Georgia Department of Community Health's, Office of Health Care Facility Regulation Hospital Rules and Regulations. Each member of the medical staff must be subject to periodic review as part of the performance improvement activities of the organization. ACEP believes that the exercise of clinical privileges in the emergency department is governed by the rules and regulations of the department. ACEP policy also states that certificates of short course completion in various cored content areas of emergency medicine, (i.e., Advanced Cardiac Life Support, Advanced Trauma Life Support, etc.) may serve as evidence of focused review; however, ABEM or AOBEM certification in emergency medicine supersedes evidence of the completion of such courses. ACEP strongly discourages the use of certificates of completion of such courses, or a specified number of continuing medical education hours in a sub-area of emergency medicine, as requirements for privileges or employment for physicians certified by ABEM or AOBEM. (Special Report Appendix III; Reaffirmed 10/21/2017)

230.994 Admitting Officer and Hospitalist Program
BD 1/24/2009
MAG believes:
(1) managed care plan enrollees and prospective enrollees should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs; (2) participation in "admitting officer" or "hospitalist programs" developed and implemented by managed care or other health care

organizations should be at the voluntary discretion of the patient and the patient's physician; (3) hospitalist programs when initiated by a hospital or managed care organization should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff by at least the same notification and voting threshold required to approve a bylaws' change to assure that the principles and structure of the autonomous and self-governing medical staff are retained; (4) Hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to "hospitalist" and that no punitive measure should be imposed on physicians or patients who decline participation in "hospitalists programs"; (5) MAG opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants. (6) hospitalists should communicate and cooperate with the attending physician's overall patient plan of care to the degree both parties have outlined and mutually approved. (Reaffirmed 10/20/2013; 10/20/2018)

230.995 Board Recertification

HD 10/5/2008

A physician should voluntarily seek Medical Specialty Board re-certification. If a board certified practitioner fails to undergo the re-certification examination; it shall not be sufficient reason to modify or withhold hospital privileges or health plan network status from a physician. The modification of, or withholding of, hospital privileges or health plan network status shall be made on the basis of the assessment of a physician's performance, rather than a requirement that a physician be board re-certified. (Resolution 107A.08) (Reaffirmed 10/20/2013; 10/20/2018)

230.996 Physician Licensure

HD 10/13/2007

MAG opposes any legislation, rule, or policy that requires hospital staff participation as a condition of physician licensure. (Resolution 204C.07; Reaffirmed 10/20/12; 10/21/2017)

230.999 Conditions of Medical Staff Privileges

HD 4/1/1984

MAG opposes any requirement that physicians accept Medicare assignment as a condition of medical staff membership. (Reaffirmed 05/2000, 10/2009; 10/2014; 10/2019)

235
Hospitals: Medical Staff-Organization

235.998 Physician Protections

HD 10/13/2007

MAG continues to advocate as a top tier priority for the protection of the rights of physicians as allowed by the laws of the State of Georgia, including 1) the right to practice medicine not usurped in any way by hospital boards or any entity not licensed to practice medicine; 2) the medical staff rights to self-governance; and 3) MAG supports legislation to prohibit economic credentialing by hospitals, insurance companies or other entities. (Resolution 307C.07; Reaffirmed 10/20/12; 10/21/2017)

235.999 Drug Screening

HD 5/1/1999

MAG adopts the Guidelines for Medical Staff Drug Screening Policies, as developed by the MAG

OMSS. MAG will work with the Georgia Hospital Association and other appropriate groups to distribute them to any organized medical staff. The eight policies are as follows:1) Urine drug and alcohol testing of employees may be appropriate in (a) pre-employment examinations of those persons whose jobs affect the health and safety of others; (b) situations in which there is reasonable suspicion that an employee's job performance is impaired by alcohol and drug use; and (c) monitoring as part of a comprehensive program of treatment and rehabilitation of alcohol and drug abuse or dependence; 2) Urine drug and alcohol testing of physicians are appropriate under these same conditions; 3) Medical staff must be involved in the development of an institution's substance abuse policy, including (a) selection of analytical methods to ensure scientific validity of the test results, (b) determination of measures to maintain confidentiality of the test results, (c) in for cause post-incident/injury testing, definition of standards for determining whether cause exists and which incidents and/or injuries will result in testing, and (d) development of mechanisms to address the physical and mental health of medical staff members; 4) MAG establishes the primacy of medical staff authority in substance abuse policy and procedures covering any pre-employment, credentialing or other phase of physician evaluation; 5) All drug and alcohol testing must be performed only with substantive and procedural due process safeguards in place; 6) MAG believes strongly in the autonomy of the hospital medical staff and does not support automatic inclusion of the medical staff in hospital personnel policies and programs, including substance abuse testing programs; 7) Hospital medical staffs should develop personnel policies and programs, including substance abuse testing, for members of the hospital medical staff and incorporate these policies in the medical staff bylaws or rules and regulations; 8) There are physicians who are not members of the medical staff, but who are employees of the hospital and their participation in hospital programs should be dictated by their employment agreements. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015

240
Hospitals: Reimbursement

240.999 Hospital Payments
HD 10/21/2012
MAG supports state and federal legislation that provides payment to hospitals up to the expected event rate that includes language acknowledging the importance of adhering to best practices based upon evidence-based medicine as well as the impossibility of achieving a zero event rate when complying with best practices. (Res. 606HC.12; Reaffirmed 10/21/2017)

245
Infant Health

245.998 Infant Mortality Risk Factors
HD 4/1/1994
MAG should work with all appropriate agencies and groups to identify risk factors for very low birth weight and develop interventions for subgroups at high risk for pre-term delivery and low birth weights. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

245.999 Infant Mortality Investigation of Deaths
HD 4/1/1994
MAG should work with all appropriate agencies and groups toward the development of a systematic investigation of all infant deaths. (Reaffirmed 05/2000; 10/2008; 10/20/2013; 10/20/2018)

255
International Medical Graduates

255.999 IMG Licensing Standards
EC 11/1/1991
MAG opposes the lowering of IMG licensing standards. (Reaffirmed 05/2000;10/5/2008; 10/20/2013; 10/20/2018)

260
Laboratories

260.996 Pap Smear Guidelines
HD 10/16/2011
MAG endorses the College of American Pathologists Guidelines for the Review of Pap Tests in the Context of Litigation or Potential Litigation. "The pap test is the most effective cancer screening test in medical history and remains the most effective screening method for the identification of premalignant cervicovaginal conditions. The Pap test has been associated with a 70 percent or greater decrease in the United States death rate from cervical cancer. If the Pap test is to continue as an effective cancer screening procedure, it must remain widely accessible and reasonably priced for all women, including those economically disadvantaged and those at high risk for cervical cancer. There must also be an understanding of the inherent limitations of this screening test. The Pap test is a screening test that involves subjective interpretation by a cytotechnologist or pathologist of the thousands of cells that are present on a typical gynecologic cytology specimen. Studies indicate an irreducible false negative rate of approximately 5 percent. Although re-screening can reduce the false negative rate, zero-error performance cannot currently be attained. Many factors, including the subjectivity involved in interpreting difficult cases and sampling problems with specimen collection, prevent zero-error performance. In the context of litigation and potential litigation, there should for these reasons be an unbiased and scientific method for review of questioned cases that is fair to both the patient and the laboratory." (additional guidelines concerning courtroom use of test results are not included) (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

260.998 Phlebotomists
HD 5/19/2001
MAG opposes legislation and regulations that would prohibit independent clinical laboratories from placing lab employees or contractors in physicians' offices (consistent with the requirements of the federal anti-kickback statute). (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

265
Legal Medicine

265.991 Delegated Medical Acts -- Compliance Funding
HD 10/16/2016
MAG supports legislation that will sufficiently fund periodic assessment of compliance with the law

governing the delegation of medical acts for the assurance of patient safety and standard of practice. (Res. 307C.16)

265.992 Expert Witness -- licensure

HD 10/19/2014

MAG supports any proposed legislation that all medical experts maintain a full or modified license in Georgia. (Res. 307C.14) (Reaffirmed 10/2019)

265.993 Expert Witness

HD 10/17/2009

MAG supports the following definition of "expert witness" for the purpose of testifying in medical malpractice cases: "An expert is a physician who has completed an Accreditation Council for Graduate Medical Education approved residency training program in the specialty in which her or she is testifying and is engaged in the clinical practice of that specialty at least 75 percent of the time." (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

265.994 Expert Witness Guidelines

HD 10/4/2008

MAG adopts the following Expert Witness Guidelines and encourages affiliated specialty societies to request the incorporation of MAG's Expert Witness Guidelines into their respective national specialty organizations. MAG also encourages the Georgia Composite Medical Board to adopt MAG's Expert Witness Guidelines:

MAG EXPERT WITNESS GUIDELINES

Expert witnesses are expected to be impartial and should not adopt a position of advocacy except as a spokesman for the field of special knowledge that they represent.

The physician serving as an expert witness should testify as to the practice behavior of a prudent physician.

A physician serving as an expert should have actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given as the result of having been regularly engaged in the active practice of such area of specialty for at least three of the last five years immediately preceding such testimony, or the teaching of such area of practice or specialty for at least half of his or her professional time as an employed member of the faculty of an accredited institution of medical education for at least three of the last five years preceding such testimony.

Prior to offering any testimony, the physician serving as an expert witness should become familiar with all pertinent data relating to the particular matter at issue in the case and should review prior and current concepts relating to the pertinent standard medical practice.

The physician serving as an expert witness should present the court with those opinions which represent the broad spectrum of medical thought and practice. The expert should honestly describe where his or her opinions vary from common practice. The expert should not present his or her own views as the only correct ones if they differ from what might be done by other physicians.

The provision of expert testimony by a physician constitutes the practice of medicine.

The physician serving as an expert witness should not concern him or herself with the legal issues of the

matter in question. Rather, the physician should champion what he or she believes to be the truth, not the cause of one party or another.

Compensation of the physician serving as an expert witness should be reasonable and commensurate with the time and effort given to preparing for his or her deposition or court appearance. Physicians should not accept contingency fees for serving as an expert witness." (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

265.999 Treatment of Minors

HD 4/1/1983

MAG believes physicians should be allowed to treat minors for venereal disease or drug abuse, or suspected venereal disease or drug abuse, without being required to have prior parental consent for such treatment. The physician may elect to advise the parents of the treatment given but should not be required to do so. MAG supports the position that any individual 18 years of age or over may give consent for medical or surgical treatment, and that any female may give such consent regardless of age or marital status when in connection with pregnancy or childbirth. (Reaffirmed 5/1/2000; 10/17/2009; 10/2014; 10/2019)

270
Legislation and Regulation

270.970 Delegated Medical Acts -- Jurisdiction

HD 10/16/2016

MAG supports legislation to bring APRNs or others who may perform delegated medical acts under the jurisdiction of the Georgia Composite Medical Board. (Res. 307C.16)

270.971 Medical Practice Act -- Physicians' Authority

HD 10/16/2016

MAG shall align its policies with the provisions of the Medical Practice Act, and other laws and rules and regulations such that they include the following eliminates: 1) Only a physician may enter a medical diagnosis for a patient; 2) A physician licensed in the state of Georgia may delegate certain specific medical acts to an APRN, with whom the physician has entered into an agreement in accordance with state law; 3) Written clinical nurse protocols for the delegation of medical acts will contain at a minimum: a) recognizable signs and symptoms and other data supported by the APRN's observation, b) the delegating physician's medical diagnosis pertinent to the observations and c) treatments appropriate to the diagnosis; and 4) Treatments ordered, including prescriptions under protocol, will be limited to those contained in the written protocol for the certain medical act delegated (Res. 301C.16)

270.972 Citizens with Disability -- Benefits

HD 10/18/2015

MAG supports the implementation of the Achieving a Better Life Experience (ABLE) Act of 2014 at the state level so that Georgia's disabled citizens may remain in the workforce and not lose disability benefits. (Res. 301C.15)

270.973 Marketing Practices

HD 10/17/2015

MAG opposes deceptive marketing practices by third party carriers and recommends that the

Commissioner of Insurance investigate these practices and publicly report the Department's findings. (Special 04.15 Appendix III)

270.974 Impaired Physicians Practice Act

HD 10/18/2014

MAG supports legislation and policy with adequate funding to establish an impaired physician treatment program which operates efficiently and effectively to assess and treat impaired physicians; MAG further supports policy mandating that medical students be made aware of these programs as a part of their curriculum. (Special Report 4, Attachment III) (Reaffirmed 10/2019)

270.975 Independent Payment Advisory Board

HD 10/21/2012

MAG supports federal legislation to dissolve the Independent Payment Advisory Board (IPAB) and retain the right of physicians to determine which therapies are in their patients' best interests. (Res. 604HC.12; Reaffirmed 10/21/2017)

270.978 Scope of Practice -- Opposes Expansion

HD 10/17/2009

MAG continues to vigorously oppose legislation and regulatory action that expand the scope of practice for non-physician health care providers. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

270.979 Civil Justice Reform

HD 10/4/2008

MAG supports Civil Justice Reform that includes the following: a) $250,000 cap on non-economic damages --Damages on pain and suffering should be limited to $250,000 in medical malpractice cases; b) Limited liability for emergency department care --Non-economic damages should be limited in situations involving emergency care and related follow-up care, except in cases of gross negligence; c) Collateral source offsets --Damage awards should be reduced by amounts paid from other sources, such as health or disability insurance; d) Reform of joint and several liability -Damages should be apportioned according to degree of fault; e) Reform of expert witness qualifications --Physicians testifying as expert witnesses should be limited to individuals licensed by the appropriate regulatory agency and actively practicing or teaching in the same specialty area as the defendant; f) Limit on attorney fees --Fees that attorneys may take from an award should be limited to reasonable amounts; g) Contributory negligence --Damages should be accurately and fairly apportioned based on the degree of fault of the plaintiff and h) Periodic payment of damages -Defendants should be allowed to pay damages over a period of time rather than in a lump sum. (Special Report, Appendix III; Reaffirmed 10/20/2013; 10/20/2018)

270.980 Provider Tax

HD 10/13/2007

MAG opposes any new tax on physician practices or any new tax on ancillary services provided by physicians or their practice. (Resolution 314-07; Reaffirmed 10/20/12; 10/21/2017)

270.981 Present on Admission

HD 10/13/2007

MAG supports efforts by the AMA to repeal the "Present on Admission Policy" as contained in the Deficit Reduction Act. (Resolution 109A.07; Reaffirmed 10/20/12; 10/21/2017)

270.982 Sales Tax

HD 10/13/2007

The Medical Association of Georgia opposes imposing a tax on professional services or alter legislation to exclude physician services or, in the alternative, permitting physicians to pass the cost of the tax on to their patients without violating their contractual obligations to insurers. (Resolution 317C.07; Reaffirmed 10/20/12; 10/21/2017)

270.985 Health Care Costs

HD 9/30/2006

MAG supports legislation that allows the expenditures by individuals for health care services as well as for health care insurance to receive the same favorable tax treatment as received by business entities for the same expenditures. (Reaffirmed 10/16/2011; 10/15/2016)

270.987 Letter of Non-Reviewability

HD 9/30/2006

The Medical Association of Georgia supports legislation that eliminates the financial threshold for Letters of Non-Reviewability. (Reaffirmed 10/16/2011; 10/15/2016)

270.988 Prompt Pay and ERISA

HD 9/30/2006

MAG supports legislative and/or regulatory reform that requires equal enforcement of the "Georgia Prompt Pay Act," closing the loopholes that allow ERISA plans and companies that are self-insured to escape enforcement to the financial detriment of health care providers. (Reaffirmed 10/16/2011; 10/15/2016)

270.993 Any Willing Provider

HD 8/22/2003

The Medical Association of Georgia supports an "any willing provider" law, requiring health insurers to accept any provider willing and qualified to participate in their managed care plans. (Resolution 312C-03) (Reaffirmed 10/5/2008: 10/20/2013; 10/20/2018)

270.994 Collective Bargaining

HD 8/22/2003

MAG supports laws that will allow physicians to collectively negotiate with large insurers. (Committee 12-03, Recommendation 5) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

270.997 Collective Bargaining

HD 5/1/1999

MAG supports legislation in Congress that allows physicians to engage in collective bargaining and MAG supports antitrust reform as a top legislative priority of the AMA, Resolution 305 & Committee 10, Recommendation 1 (Reaffirmed 10/2005; 0/16/2010; 10/17/2015)

275
Licensure and Discipline

275.980 Telemedicine and Telehealth Services -- Support

HD 10/21/2018

MAG supports the removal of barriers to the provisions of telemedicine and telehealth services for physicians who are licensed in the State of Georgia and supports access to primary care physicians and

specialty physicians care for all citizens in Georgia by promoting rural development including state and federal funding to expand broadband and internet services to rural and remote areas of the State. (Resolution 606R.18)

275.981 Interstate Medical Compact

HD 10/22/2017

MAG supports legislative measures that will provide Georgia the ability to become an interstate medical licensure compact so as to assure that Georgia physicians maintain individual state licensure by facilitating applications and authorization of these licenses at the state level. (Res. 304C.17)

275.982 Truth In Advertising -- Certification

HD 10/18/2015

MAG supports legislation that: 1) requires all health care professionals – physicians and non-physicians – to accurately and clearly disclose their training and qualifications to patients; and 2) states that a medical doctor or doctor of osteopathic medicine may not hold oneself out to the public in any manner as being certified by a public or private board including but not limited to a multidisciplinary board or "board certified," unless all of the following criteria are satisfied: a) the advertisement states the full name of the certifying board; and b) the board is either: 1) a member of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA); or 2) requires successful completion of a postgraduate training program approved by the Accreditation Commission for Graduate Medical Education (ACGME) or the AOA that provides complete training in the specialty or subspecialty certified, followed by prerequisite certification by the ABMS or AOA board for the training field and further successful completion of examination in the specialty or subspecialty certified. (Resolution 313C.15)

275.983 Specialty Board Recertification

HD 10/19/2014

MAG opposes the restriction of physicians to practice medicine in Georgia based on the lack of a specialty board recertification. (Resolve 2, Res. 113A.14). (Reaffirmed 10/2019)

275.985 Maintenance of Licensure

HD 10/19/2014

MAG opposes any efforts to use or require the Federation of State Medical Board Maintenance of Licensure (MOL) program as a condition of licensure. (Res. 108A.14) (Reaffirmed 10/2019)

275.986 Proper ID -- Medical Professionals

HD 10/20/2013

MAG supports that all mid-level providers and health care extenders introduce themselves accurately and give their correct titles when delivering care, and to accurately identify the supervising physician, including providing contact information and that such health care extenders and the supervising physicians wear an identification badge that clearly and accurately states their correct titles and degrees. (Res. 702S.13; Reaffirmed 10/20/2018)

275.987 Telemedicine Licensure

HD 10/20/2013

MAG supports telemedicine licensure by individual states, and opposes efforts to change such to federal licensure of telemedicine. (Res. 302C.13; Reaffirmed 10/20/2018)

275.989 Non-Physician Personnel

HD 10/20/2012

As a matter of patient safety, MAG opposes the performance of medical procedures by non-physician personnel who are not medically trained and supervised. Actions such as the ordering of images, the administration of vaccines and other injectables should not be performed by non- physicians unless administration is done pursuant to a physician protocol and in the case of vaccine and injectable administration, a physician's prescription. (Special Report Appendix III: Reaffirmed 10/21/2017)

275.990 Discrimination in Licensing

HD 10/16/2011

MAG opposes discrimination against physicians on the basis of being a graduate of a foreign medical school and supports state and territory responsibility for admitting physicians to practice, and urges licensing jurisdiction of medical licenses on an assessment of competence as determined by the state and territory issuing the license. (HOD 2011--policy review extraction) (Reaffirmed 10/15/2016)

275.991 State Medical Licensure Protection

HD 10/16/2011

MAG supports maintaining medical licensure at the state level without a requirement to tie participation in a third party payer plan to licensure. (Res. 301.11) (Reaffirmed 10/15/2016)

275.992 National Licensure

HD 10/16/2011

MAG strongly opposes any implementation of a national licensure for physicians and rejects the Maintenance of Certification as a requirement to maintain state licensure. (Res. 102A.11) (Reaffirmed 10/15/2016)

275.998 Laser Surgery Training

HD 4/1/1991

MAG believes that laser surgery and therapy should be performed only by a licensed physician who meets appropriate professional standards as evidenced by training, experience and credentials. MAG further encourages and supports state legislation and rule making by state medical boards in support of this policy. (Reaffirmed 10/17/2009; 10/2014; 10/2019)

275.999 Stratified Licensure -- Opposition

HD 4/1/1989

MAG opposes any efforts on the part of government to implement or impose any stratified, tiered, or restrictive licensure structure that limits the practice of a duly licensed physician. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

280
Long-Term Care

280.985 Home Care Services

HD 10/21/2012

MAG supports state legislative efforts to establish programs that allow appropriate Medicaid patients the support needed to maintain independence in their living situation. (Res. 311C.12; Reaffirmed 10/21/2017)

280.986 Nursing Home Care Payments

HD 10/17/2009

MAG supports Medicare and Medicaid payments to nursing homes based on the actual level of care required for each patient. Providers of nursing home care should be required to adopt a process for admissions to skilled nursing home beds that do not discriminate against the more debilitated patient. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

280.987 Personal Care Homes

HD 10/4/2008

MAG supports the licensure and regulation of personal care homes. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

280.988 HSAs to Finance Long-Term Care

HD 10/4/2008

MAG supports Health Savings Accounts as a method of financing long-term care. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

280.989 Long-Term Care/Hospice Care

HD 10/16/2010

MAG Principles on Long-Term Care and End-of-Life Planning are: 1) MAG supports incentives to increase the numbers of physicians trained in geriatric medicine to meet the growing needs of the elderly population. We believe all physicians must be educated, especially primary care physicians, on how to meet the unique care needs of older adults, including those in nursing homes; 2) MAG encourages support for the creation of new models for providing long-term care, including those for providing care coordination for older adults at risk of functional decline and identification of models that improve quality and reduce costs; 3) All patients should be encouraged to prepare ahead of time concerning the possible future need for long-term care services, including the importance of early preparation through saving and investing, and the option to purchase long-term care insurance; and 4) Patients should be encouraged to express in advance their preferences regarding the extent of treatment after cardiopulmonary arrest or other life-threatening events, especially patients at substantial risk of such an event. During discussions regarding patients preferences, physicians should include a description of the usefulness of comprehensive geriatric assessments and care coordination services for high-risk and high-cost beneficiaries with multiple chronic health conditions, nursing home care and other alternatives, which are available, including at-home care and hospice care. Physicians should be able to advise their patients as well on end-of-life planning including the use of aggressive therapies, the usefulness of "living wills," advance directives, a durable power of attorney and "Do Not Resuscitate" orders, Special Report 04.10, III (Reaffirmed 10/17/2015)

280.992 Medical Director Certification

HD 5/1/1997

MAG encourages medical directors of nursing homes to take advantage of the American Medical Directors Association certification training programs. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

280.996 Improve Long-Term Care

HD 4/1/1991

MAG will continue to work with all appropriate agencies to develop and implement recommendations to improve long-term care in Georgia. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

280.999 Quality of Nursing Home Care
HD 4/1/1983
MAG believes its position that high-quality medical care should be assured for all nursing home patients. The Alliant GMCF is best qualified to do peer review for quality health care for nursing home patients. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

285
Managed Care

285.973 Managed Care Contracts and Education
HD 10/17/2015
MAG supports the annual review of a sample of managed care contracts in order to develop education and guidance to promote awareness about critical red flags in contract design so that members can make informed decisions when entering into payer contracts. (Special 04.15 Appendix III)

285.975 Medicaid -- Access to Care
HD 10/17/2009
The Medical Association of Georgia opposes any managed care of financing reform that will adversely affect the access to care of Georgia's patients or decrease participation of physicians in those plans, especially in rural communities. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

285.976 HIPAA
HD 10/5/2008
The Medical Association of Georgia believes that Title I HIPAA exclusions have a negative impact on access and continuity of care for Georgians employed in small businesses and MAG supports efforts on the national level to study and address these issues. (Resolution 105A.08) (Reaffirmed 10/20/2013; 10/20/2018)

285.977 Physician Negotiations
HD 10/4/2008
MAG supports federal legislation to allow physicians to negotiate more substantially regarding quality of care, fees, and peer review programs. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013;10/20/2018)

285.978 Hold Harmless Clauses
HD 10/4/2008
MAG encourages detailed reviews of the hold harmless clauses that are within managed care contracts. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

285.980 Prior Approval
HD 10/29/2004
The Medical Association of Georgia opposes prescription prior approval in the state of Georgia. (106AB.04. res 1.) (Reaffirmed 10/2009; 10/2014; 10/2019)

285.981 Prior Approval
HD 5/4/2002
MAG opposes the use of prior approval policies that are inappropriately based on economic factors

without the support of clinical evidence. MAG urges regulators, insurers, and others, in both the public and private sector, to reduce and eliminate such policies; MAG urges legislative or regulatory action, at the state level, to prevent the further utilization of inappropriate prior approval of pharmaceuticals. (Res: 300C-02; Reaffirmed 10/13/07;10/20/12; 10/21/2017)

285.982 HMO Investigations

HD 10/16/2010

MAG urges its members to report abusive and unrealistic demands made pursuant to HMO, PPO and other managed care investigations in order that MAG may take appropriate action to help prevent and stop such practices, Special Report 04.10, III (Reaffirmed 10/17/2015)

285.989 Financial Incentives

HD 4/1/1996

MAG opposes the use of managed care techniques which adversely impact patient care and the physician/patient relationship through the use of financial incentives designed to limit a patient's choice of physician or patient's choice of services and recommends the continuation of fee for service and a doctor/patient relationship. (Reaffirmed 05/02; 10/13/07;10/20/12; 10/21/2017)

285.992 Due Process

HD 4/1/1996

MAG supports legislation that requires managed care entities to hold a due process hearing on any issue involving the appropriateness of medical care, before any sanction can be taken against a physician for such action. (Reaffirmed 05/02; 10/07; 10/20/12; 10/21/2017)

285.994 Managed Care -- Liability

HD 4/1/1996

MAG supports legislation that would require liability on the part of any managed care entity for any decision it makes which breaches the acceptable standards for medical care. (Reaffirmed 05/2002; 10/13/07; 10/20/12; 10/21/2017)

285.999 Capitation Reimbursement

HD 4/1/1987

While recognizing the rights of a practicing physician to enter into contractual arrangements with any alternate health care system he/she deems desirable and necessary, as a matter of policy, MAG opposes individual capitation reimbursement systems. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

290
Medicaid

290.965 Access to Care -- Block Grants

BD 4/21/2018

MAG should work to maintain and strengthen the viability of the Georgia Medicaid Program and oppose any state legislative or other efforts to curtail or diminish the program, which could reduce critical access to care that Medicaid provides to Georgians. MAG shall only consider a support of block grants from the Federal Government to the State of Georgia if the amount of the grant is sufficient to cover the cost of Medicaid.

290.966 Medicaid Services -- Autism Treatment Payment

HD 10/22/2017

MAG supports the concept of multi-agency state autism collaborative in which a physician with autism treatment experience, a psychologist with autism experience, or a community service board (psychiatrists or physicians specializing in the treatment of mental health patients) can supervise board-certified Behavior Analysts (BCBAs) to provide Applied Behavior Analysis (ABA), and bill Medicaid for those services. (Res. 110A.17)

290.967 Waiver -- Coverage Gap

HD 10/16/2016

MAG supports a Medicaid waiver to close the coverage gap in Georgia in a fiscally responsible and sustainable way that meets the needs of patients and physicians which includes, but is not limited to, the following: 1) that patients receive proven, cost-effective care that is not impeded by unnecessary barriers to enrollment or unaffordable cost-sharing; and 2) that such a waiver eliminate regulatory barriers to providing proven, cost-effective care, and seek parity for all physician services with the Medicare fee schedule. (Res. 312C.16)

290.968 Medicaid Expansion -- Waiver

HD 10/20/2013

MAG supports Georgia seeking a waiver from the U.S. Department of Health & Human Services (HHS) Secretary to allow Georgia to use the Medicaid expansion funds to buy private insurance in the state health insurance exchange for eligible Georgia citizens at or below 138 percent of the federal poverty level. (Res. 305C.13; Reaffirmed 10/20/2018)

290.969 Primary Care Pay Parity

HD 10/19/2014

MAG supports legislation that extends the Medicaid Primary Care Pay Parity Program; and supports including in the program obstetrician/gynecologists. (Res. 306C) (Reaffirmed 10/2019)

290.970 Indigent Care

HD 10/20/2013

MAG supports a state constitutional amendment to allow physicians who provide indigent care to be eligible to receive reimbursement from the Indigent Care Trust Fund. Additionally, MAG supports legislation that would allow physicians to receive tax credit when they provide an agreed upon percentage of care to indigent populations. (Special Report 04.13, Attachment III; Reaffirmed 10/20/2018)

290.971 Medicaid Expansion

HD 10/21/2012

MAG support innovations and modifications of the Georgia Medicaid program balancing the needs of Georgia's uninsured patients with the need to achieve a sustainable solution to the budget shortfalls and expected future financial challenges. (Res. 601HC.12, 605HC.12 and 611HC.12; Reaffirmed 10/21/2017)

290.972 Medical Fraud in Medicaid

HD 10/16/2011

MAG supports continued review of the eligibility process when applying for Medicaid, and supports a requirement documenting federal and state income tax returns to determine actual need and qualifications for public assistance in order to limit or eliminate fraudulent usage of Medicaid funds by state and federal governments. (Res. 103A.11) (Reaffirmed 10/15/2016)

290.973 Medicaid Eligibility Expansions

HD 10/17/2009

MAG supports legislation that would ensure that 90 percent of those individuals under 200 percent of the federal poverty level, be enrolled in Medicaid or SCHIP before eligibility in those programs are expanded. (Officer 1, Rec. 7; Reaffirmed 10/2014; 10/2019)

290.974 Federal Poverty Level

HD 10/17/2009

MAG supports expansion of Medicaid for low-income families up to 185 percent of the federal poverty level (current level as of July 2009 is about 50 percent of the federal poverty level.) (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

290.975 Nurse/Nurse Midwives Medicaid Payments

HD 10/4/2008

MAG supports Certified Nurse Midwives, Nurse Practitioners and Physician Assistants, employed by and under the direction of a physician and seeing a patient in conjunction with a physician, being reimbursed at the same fee as the physician. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

290.976 Administrative Burdens

HD 10/4/2008

MAG urges that both legislative and administrative efforts be made with the Georgia Department of Community Health and the Georgia General Assembly to reduce the administrative burden for physicians treating Medicaid patients, so as to remove bureaucratic impediments to physician participation in the program. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013;10/20/2018)

290.977 Dual Eligibility

HD 10/13/2007

The Medical Association of Georgia (MAG) supports 1) legislation and/or use administrative change in the Georgia Medicaid Program which allows payment levels for dual-eligible Medicare patients to be reversed to the full 20% Medicare co-insurance and deductibles level; 2) MAG supports legislation and/or administrative changes in the Georgia Medicaid Program which requires Georgia Medicaid to accept paper claims for secondary coverage on dual-eligible Medicare claims without the 90-day holding period if the Medicare EOB clearly shows no "cross over" occurred 3) MAG supports legislation and/or administrative change in the Georgia Medicaid Program which requires Georgia Medicaid to pay any secondary claim if the EOB from Medicare is attached and no further extra information is needed on the CMS billing form and, 4) MAG supports legislation and/or administrative change in the Georgia Medicaid Program which requires Georgia Medicaid to accept modifiers on secondary claims consistent with Medicare on duel-eligible claims. (Resolution 207B.07 Resolves 1-4; Reaffirmed 10/20/12; 10/21/2017)

290.978 CMOs

BD 4/14/2007 MAG opposes continued implementation of Medicaid CMOs. (Reaffirmed 10/20/12; 10/21/2017)

290.983 Reimbursement Rates

HD 8/22/2003

MAG believes that Medicaid reimbursement rates should be no less than 100 percent of RBRVS.

(Committee 12-03, Recommendation 3) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

290.984 Tax Credits
HD 5/1/1999
MAG supports allowing a tax credit or tax deduction of the Medicaid allowable in lieu of payment from the state, Res. 300C-99 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

290.991 Voucher System
EC 5/1/1995
MAG supports the development of programs that allow the Medicaid population to utilize a voucher system to purchase their choice of health insurance including HMO, PPO, indemnity, or acquire a medical savings account. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

290.993 Drug Utilization Review
HD 4/1/1993
MAG supports legislation that establishes the confidentiality of physician profiles (i.e., deviations from established standards) that have been formed in the course of Drug Utilization Review by Medicaid agencies or other state agencies. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

290.997 Physician Participation
HD 4/1/1991
MAG should continue to work with the Department of Medical Assistance to improve policy and operational factors which would facilitate and encourage physicians to more fully participate in the program. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013;10/20/2018)

295
Medical Education

295.987 Curriculum -- Prescription Drug Misuse
HD 10/16/2016
MAG supports the incorporation of education regarding the prevention and management of prescription drug misuse into medical school curriculum. (Res. 604S.16)

295.988 Students Freedom of Choice
HD 10/20/2013
MAG supports medical students having the right to select the residency of their choice, and the freedom to choose their specialty. MAG opposes specialty quotas and other negative sanctions imposed on medical schools and/or students while maintaining support for an increased participation of students in primary care. (Special Report 04.13, Attachment III; Reaffirmed 10/20/2018)

295.989 Primary Care Physicians
HD 10/17/2009
MAG recognizes its commitment to the important role of primary care in medicine and believes there should be increased financial incentives for physicians practicing primary care. (Officer 1, Rec. 3; Reaffirmed 10/2014; 10/2019)

295.991 Medical Student Training

HD 5/4/2002

MAG supports standardized Advanced Cardiac Life Support (ACLS) training for all medical students prior to clinical clerkships and strongly encourages medical schools to fund ACLS training for medical students. (Res: 113AB-02; Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

295.994 Mandatory Student Obligations

HD 4/1/1994

MAG opposes mandatory service obligations imposed upon students participating in government-subsidized medical schools. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

295.995 Primary Care Graduates

HD 4/1/1993

MAG supports increasing the total number of medical graduates across the state entering primary care. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

295.997 Loan Defaults

HD 4/1/1993

MAG considers as unethical the willful default of a physician's obligation to repay (either by service or monetary remuneration) loans incurred to finance his/her medical education. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

300
Medical Education: Continuing

300.984 Substance Abuse Curriculum and Education

HD 10/16/2016

MAG supports substance abuse curriculum and CME opportunities to its membership with continuing education materials made available including but not limited to screening, brief intervention, and referral to treatment (SBIRT) diagnostic criteria...(Res. 602S.16)

300.985 CME -- Business and Economics of Medicine

HD 10/20/2013

MAG supports development of more CME in the areas of medical economics and business, and design of curriculum on medical economics and business skills, in medical schools. (res. 315C.13; Reaffirmed 10/20/2018)

300.986 Accredited Sponsor Eligibility

HD 10/20/2013

MAG, through its Continuing Medical Education Committee, supports the following Accredited Sponsorship Eligibility Policy:

1. MAG's Department of Education manages the accreditation process for organizations wishing to offer Category 1 Credit toward the AMA Physician's Recognition Award. MAG is granted the authority to accredit intrastate providers through its Recognition by the Accreditation Council for Continuing Medical Education (ACCME). Organizations accredited by MAG have the authority to offer physicians AMA PRA Category 1 Credit(s) ^{TM} which meet Georgia license renewal requirements. 2. MAG will consider

accrediting organizations led by physicians and which are focused on physician continuing medical education programs.3. MAG accredits the following institutions if they choose to seek accreditation:
a. hospitals
b. health systems
c. state physician membership organizations
d. specialty societies, and
e. non-profit organizations
The only exception to the above eligibility categories may be an applicant offering programs meeting area professional needs not otherwise being met by any other CME accredited sponsor. (Special Report 04.13, Attachment III; Reaffirmed 10/20/2018)

300.987 Diversity Training

HD 10/21/2012
MAG supports continuing medical education training in diversity and cultural competence for all practicing physicians. (Res. 302C.12; Reaffirmed 10/21/2017)

300.988 Mission Statement of Intra-State CME Accreditor

HD 10/16/2011
MAG recognizes that physicians' professional responsibilities entail a commitment to a lifetime of learning. MAG has been recognized by the ACCME as the Accreditor of Intrastate providers of continuing medical education in Georgia. In this role, MAG strongly supports the development and accreditation of quality CME programs in state and metropolitan specialty societies, voluntary health organizations, and especially in local hospitals. For hospitals, the Joint Commission requires that every staff member's participation in hospital CME activities should be documented and reviewed at the time of reappointment. The Joint Commission requires that at hospital and health care organizations it accredits, physicians with clinical privileges document their CME. The Joint Commission will accept correctly completed AMA PRA applications stamped “approved” by the AMA as documented physician compliance with Joint Commission CME requirements. CME can play an essential role in supporting hospital accreditation requirements while improving practice and patient care; beyond this, MAG believes that each institution's medical staff should decide the types of CME activities that are appropriate for itself. In addition to the minimum amount of continuing medical education mandated by state law (i.e., as of 1992, physicians are required to complete 40 hours of Category 1 credits, or recognized credits, per every two years), all members of MAG are strongly encouraged to follow the recommendations of their specialty societies, specialty boards, and local hospitals on the desirable level of participation in CME activities. We continue to believe that any system of mandatory CME should reflect the diversity of physicians' educational needs and individuals' pattern of learning. There is no CME requirement for membership in MAG. The physician's best motivation for participating in CME is the desire to maintain professional knowledge and ability through education. Voluntary achievement in CME is a major priority not only for the MAG's Continuing Medical Education Committee, but for the entire MAG. To accomplish this, MAG encourages all of its members to qualify for the AMA's Physician Recognition Award. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

300.991 Educational Focus

HD 8/22/2003
The educational programs offered by MAG should emphasize legal, legislative and regulatory areas that affect the practice of medicine. (Committee 18, Strategic Planning/Finance) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

300.992 CME Confidentiality Policy

EC 5/16/2003

CME Committee/Surveyor Confidentiality Policy: The Medical Association of Georgia has been recognized by the Accreditation Council of Continuing Medical Education (ACCME) as the accredited body for hospitals and other medical organizations in Georgia that offer programs of continuing medical education. The accrediting process necessarily involves the collection and evaluation of the data and information, some of which may be sensitive or proprietary information. MAG has agreed to be bound by the confidentiality policies of the ACCME as it carries out its accrediting function.

Consistent with the ACCME policy on confidentiality, MAG may publish and release to the public, including on the Accreditation Council for Continuing Medical Education (ACCME) and MAG web sites, names of CME providers accredited by MAG, and names of CME providers whose accreditation by MAG has been withdrawn. MAG may also publish and release to the public, including on the ACCME and MAG web sites, accumulated data that does not specifically identify individual CME providers.

MAG will maintain the following as confidential, except as required for MAG accreditation purposes, or as may be required by legal process, or as otherwise authorized by the CME provider to which it relates: 1) Confidential information acquired by MAG from a provider during the accreditation process for that CME provider except for accumulated data that does not specifically identify individual CME providers; 2) Correspondence and memoranda within MAG relating to the accreditation process for a CME provider; 3) Correspondence between MAG and a CME provider relating to the accreditation process for the CME provider; and 4) MAG proceedings relating to a CME provider.

In order to protect the confidential information, MAG and its CME Committee members and surveyors are required: 1) Not to make copies of, disclose, discuss, describe, distribute, or disseminate in any manner whatsoever, including in any oral, written, or electronic form, any confidential information that MAG or its Committee members receive or generate, or any part of it, except directly for MAG accreditation or recognition purposes; and 2) Not to use such confidential information for personal or professional benefit, or for any other reason, except directly for MAG accreditation purposes. (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

300.998 CME Programs

HD 4/1/1992

MAG encourages the development of more continuing medical educational programming by MAG. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

305
Medical Education: Financing and Support

305.989 Graduate Medical Education -- Funding

HD 4/1/1985

MAG opposes cuts in funding of post graduate medical education in the absence of stable alternate funding sources. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

305.990 Residency Programs -- Funding

HD 10/20/2013

MAG supports state efforts to increase funding for all residency programs designed to train physicians to practice medicine in Georgia. (Res. 309C.13; Reaffirmed 10/20/2018)

305.991 Tax Credit -- Student Clerkships

HD 10/20/2013

MAG supports efforts to provide tax credits for non-financially compensated community-based physicians providing third-year core clerkships for Georgia medical students including those made by the Georgia Statewide Area Health Education Center (AHEC). (Res. 301C.13; Reaffirmed 10/20/2018)

305.992 Student Clerkships

HD 10/21/2012

MAG supports Georgia hospitals offering medical student clerkships, especially those in primary care and that directly or indirectly benefit from state funding, giving preference to Georgia residents who are U.S. citizens attending U.S. or Educational Commission for Foreign Medical Graduates (ECFMG) accredited medical schools. and who have passed the relevant USMLE Steps 1 and intend to practice in Georgia. (Res. 310C.12' Reaffirmed 10/21/2017)

305.993 Medical College of Georgia

HD 10/20/2012

MAG supports the position that the Medical College of Georgia in Augusta will continue to be the sole public medical education institution in Georgia and will be allowed to continue to expand its medical educational and residency programs in Georgia to ensure the outcome of an appropriate supply of physicians to take care of patients throughout the state. (Special Report Appendix III; Reaffirmed 10/21/2017)

305.995 Educational Activities

HD 8/22/2003

MAG will continue to develop its educational activities with the goal of making MAG’s Department of Education revenue neutral or profitable. (Committee 18F.03, Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

305.997 MCG Health, Inc.

HD 5/19/2001

MAG opposes the concept of MCG Health, Inc., which privatizes the state's only state-run teaching hospital. (Res 310C.01) (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

305.999 Primary Care Training

HD 4/1/1983

MAG actively supports and encourages expansion of the training in family practice and other primary care practices and encourages the Governor and the Legislature to provide state support for this training. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

310
Medical Education: Graduate

310.995 Primary Care GME Graduates

HD 10/20/2013

MAG support the efforts, including those of the Georgia Statewide Area Health Education Centers (AHEC), to retain more Georgia primary care GME graduates and to recruit more Georgia medical student graduates into Georgia primary care GME programs. (Res. 303C.13; Reaffirmed 10/20/2018)

310.997 Physician Graduates
HD 10/21/2012
MAG supports development of a program for physician graduates seeking employment in Georgia and shall convey this support to the Georgia Board for Physician Workforce. (Res. 303C.12; Reaffirmed 10/21/2017)

310.998 Pediatric Residency Programs
HD 4/1/1991
MAG supports increased state support of General Pediatric Residency programs designed to provide primary pediatric physicians. (Reaffirmed 05/2000 10/5/2008; 10/20/2013; 10/20/2018)

315
Medical Records

315.993 Electronic Records -- Waiver
HD 10/18/2015
MAG shall advocate for waivers to allow physicians who are not confident with the use of electronic health records to not be financially punished or fined for not using an electronic record program.(Res. 307A.15)

315.994 Electronic Health Record -- Usability
HD 10/18/2015
MAG supports the 2014 AMA position paper that outlines eight priorities to improve EHR usability for physicians and other stakeholders in the health care industry, including the following: 1) EHR systems should be designed to enhance physician-patient communication and engagement; 2) EHR systems should be support team-based care by maximizing each person's productivity in accordance with state licensure laws and allow physicians to delegate tasks as appropriate; 3) EHR systems should be designed to enhance care coordination across the continuum of care; 4) EHR systems should offer product modularity and configurability to meet individual practice requirements; 5) EHR systems should support medical decision making with concise, context sensitive and real- time data; 6) EHR systems should facilitate connected health care across care settings and enable both exporting data and properly incorporating data from other systems; 7) EHR systems should be interoperable with patient mobile technology to support patient engagement; and 8) EHR systems should be designed with end-user input and EHR technology should facilitate post-product implementation feedback. (Resolution 108A.15)

315.995 Electronic Health Record -- Improving Technology
HD 10/18/2015
MAG supports the American Medical Association in its advocacy with the U.S. Department of Health and Human Services, IT experts, researchers and executives to reframe policy around the desired future capabilities of Electronic Health Records technology to enhance patient care, improve productivity and reduce administrative costs. (Resolution 108A.15)

315.996 Written and Verbal Hospital Orders
HD 10/16/2010
MAG believes that medical records should contain written orders on patients which are signed by the

practitioner, or a postgraduate physician in an approved training program as determined by the medical staff, giving the order and such orders shall be dated. Verbal and telephone orders, in accordance with medical staff rules, shall be dictated by a practitioner, or a postgraduate physician in an approved training program as determined by the medical staff, to order licensed personnel who are qualified by training and education to receive the orders, subject to the conditions below:
1. Those licensed personnel which are designated as qualified to receive and record verbal and telephone orders are identified by position in the medical staff rules; 2. Verbal and telephone orders are signed, dated and time recorded by the person to whom they are dictated, with the name of the practitioner issuing the order entered next to the signature of the person taking the order; 3. Verbal and telephone orders are used, when appropriate, in accordance with defined medical staff rules and accepted standards of practice; 4. Verbal and telephone orders are not to be used for procedures or medications which are specified in medical staff rules as not to be prescribed by verbal/telephone order; 5. The hospital has in place and maintains an effective quality assurance system for checking accuracy and appropriateness of practitioners' orders and safeguarding against fraudulent recording of orders; 6. The hospital documents training for the medical and nursing staff in the procedures and conditions for issuing and recording verbal and telephone orders; and 7. Authentication of verbal and telephone orders, verifying that orders are correct and appropriate for the patient, will be done by either the practitioner giving the order or by such practitioner's covering or group practice physician, Special Report 04.10, III (Reaffirmed 10/17/2015)

315.997 Medical Records -- Use

HD 5/1/1998
MAG supports the integrity of the medical record as an instrument of clinical care and opposes unnecessary use of the medical record for billing purposes. Resolution 201 (Reaffirmed 10/2005;10/16/2010; 10/17/2015)

315.998 Confidentiality

HD 5/1/1998
MAG supports the enforcement of current rules mandating that third party carriers and other health care providers not share patient's medical information with any other entity without the authorized consent of the patient, Resolution 307C (Reaffirmed 10/205;10/16/2010; 10/17/2015)

315.999 Attorneys' Requests

HD 4/1/1992
MAG recommends that physicians request specificity as to subject matter and scope from attorneys seeking to obtain medical records involved in litigation. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

320
Medical Review

320.995 Hospital Utilization Review

HD 10/16/2010
MAG opposes the intrusion of insurers into legitimate, objective, protocol-based hospital utilization review activities in an effort to influence such decisions. Special Report 04.10, III (Reaffirmed 10/17/2015)

320.998 Utilization Review
HD 4/1/1988
MAG supports: (1) a cooperative study with third party payers and utilization reviewers to develop a streamlined UR system; (2) reminding physicians to release confidential information only after securing a patient medical release; and (3) a physician's authority to charge third party payers for responding to certain extensive inquiries. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

320.999 Concurrent Review
N/A 4/1/1981
MAG is supportive of concurrent medical review provided it contains a timely payment mechanism. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

330
Medicare

330.972 Meaningful Use - Stage 3
HD 10/18/2015
MAG supports AMA efforts to advocate for HHS to pause the Meaningful Use (MU) Stage 3 regulation, and evaluate the MU program. (Res. 109A.15)

330.973 ICD-10 Implementation
BD 10/16/2015
MAG supports AMA and CMS in addressing the challenges that a large number of physicians and medical practices face in making the transition to ICD-10 billing codes that become effective October 1, and supports a dual ICD-9/ICD-10 reporting period for physicians and medical practices struggling with the transition.

330.974 Sustainable Growth Rate -- Repeal
HD 10/18/2014
MAG supports repeal of the sustainable growth rate (SGR). (Special Report 4: Attachment III) (Reaffirmed 10/2019)

330.975 Acceptance of Patients
HD 10/17/2009
MAG urges physicians to continue to see Medicare patients. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

330.976 Payment Denial
HD 10/17/2009
MAG opposes "medical necessity" definition in CMS rules and regulations and the use of other CMS-developed "standards" as a measure of quality care and as a basis of payment denial. (Special Report, Attachment III; Reaffirmed 10/2014; 10/2019)

330.977 Election Period
HD 10/5/2008

MAG believes that physicians in the Medicare program should be given the option of a semiannual participation election period which occurs at the end and middle of the calendar year. (Resolution 106A.08) (Reaffirmed 10/20/2013; 10/20/2018)

330.978 Parity in Payment

BD 4/19/2008

MAG supports parity in payment rates between HMO Medicare and traditional Medicare. (Reaffirmed 10/20/2013; 10/20/2018)

330.979 Prescription Drug Program -- Medicare

BD 4/19/2008

MAG supports changing the appeal process in the Medicare Prescription Drug Program Part D by eliminating the requirement for a signed statement from the patient and physician authorizing the physician's representation of the patient. (Reaffirmed 10/20/2013; 10/20/2018)

330.980 Prior Authorization -- Hospitals

HD 10/13/2007

MAG supports legislation that requires a hospital to obtain prior authorizations required by all health plans for inpatient services so as to ensure proper payments for hospitals and physicians. (Res. 208B-07; Reaffirmed 10/20/12; 10/21/2017)

330.981 Physician Orders

HD 10/13/2007

MAG opposes Medicare's promotion with hospitals and state quality improvement agencies allowing hospital administrations to set standing orders for influenza and pneumococcal immunizations, in place of specific physician orders and directives. (Special Report, Appendix III; Reaffirmed 10/20/12; 10/21/2017)

330.985 Medicare Reform

HD 5/1/1999

MAG supports the promotion of meaningful Medicare reform which permits patients the right to select their own physician and permits the patient and physician to enter into independent contractual relations without requiring the physician to give up his/her medical practice for any period of time. Resolution 316C.99 (Reaffirmed 10/15/2005; 10/16/2010; 10/17/2015)

330.986 Medical Necessity Clarification

BD 10/1/1998

MAG encourages CMS to find substitute language for "medically unnecessary," which more accurately reflects the reason for non-coverage of services by Medicare. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

330.988 Fraud and Abuse

HD 10/16/2010

MAG supports the repeal of the Medicare fraud and abuse provisions and sanctions as contained in the Health Insurance Portability and Accountability Act of 1996. Any audits now being required by the Evaluation and Management Documentation Guidelines should be conducted by appropriately trained and qualified personnel using reasonable policies and procedures, physicians' audit findings should be referred to the appropriate specialty society peer review committee, and remedial education should be offered to the physician before any sanctions or legal actions are imposed, Special Report 04.10, III (Reaffirmed 10/17/2015)

330.989 Whistle Blower Law
HD 5/1/1998
MAG supports changes in the HIPAA Beneficiary Incentive Program ("Whistle blower Law") legislation, as it applies to medical practices, which allows for the redress of complaints that are made without merit. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

330.990 Coding Guidelines
HD 5/1/1998
MAG supports the AMA's continued efforts, with significant practicing physician input, to greatly simplify the E&M documentation guidelines, consistent with reasonable standards and medical terminology, allowing for a test period of any proposed guidelines, Resolution 202B.98, Res. 2) (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

330.991 Audit Methods
HD 4/1/1992
MAG supports legislative or regulatory relief to eliminate the extrapolation method in physician Medicare audits. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

330.993 Payment Reform
HD 4/1/1991
MAG supports communicating ongoing federal legislative changes in Medicare payment reform to physicians in a timely manner. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

330.994 Public Education
HD 4/1/1989
MAG supports educating the public about changes in the Medicare program. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

330.998 Pre-certification
HD 4/1/1989
MAG supports allowing patients to obtain their own pre-certification authorization number. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

350
Minorities

350.999 Reduction of Racial & Ethnic Health Disparities
HD 10/16/2011
MAG supports the Georgia Department of Public Health's Office of Health Equity and its efforts to reduce racial and ethnic health disparities in Georgia. (Special Report 04.11, Attachment III; Reaffirmed 10/15/2016)

355
National Practitioner Data Bank

355.996 National Practitioner Data Bank Reform

HD 10/17/2009

MAG objects to the establishment and methodology employed by the National Practitioners Data Bank (NPDB) on the basis that the Department of Health and Human Services exceeded its statutory authority. We support vigorous efforts against broadening the scope of the NPDB) and toward remedial action to correct all operational problems, including data accuracy and completeness. We object to extended peer review reporting in view of the extreme threat this poses to confidentiality of such information and, in fact, recommend a more restrictive definition of "peer review organization" be made. We believe the Secretary should exercise his statutory authority to afford physicians and other practitioners' meaningful opportunities to dispute the accuracy of claims reported to the NPDB and to require the removal of inaccurate reports. (Special Report, Attachment III) (Reaffirmed 10/2014; 10/2019)

360
Nurses and Nursing

360.978 Doctor of Nursing Practitioners

HD 10/21/2018

MAG opposes the National Board of Medical Examiners participation in any credentialing procedures for Doctor of Nursing Practitioners (DNP) and believes that the Board should also refrain from producing test questions to certify these DNP candidates. MAG supports the position that nurses who are Doctors of Nursing Practice must practice by delegation of certain medical acts by a written clinical nurse protocol agreement of a physician and as a part of a medical team with the final authority and responsibility for the patient under the written clinical nurse protocol agreement of a licensed physician. (Special Report 03.18, Appendix I)

360.979 APRN -- Protocol Agreements

HD 10/21/2018

MAG supports the current requirement that APRNs work under a written clinical nurse protocol agreement with physicians. (Special Report 03.18 Attachment I)

360.980 APRN Prescriptive Authority

HD 10/21/2018

MAG opposes an APRN's ability to order Schedule II drugs. (Special Report 3.18, Appendix 1II)

360.981 APRN -- Radiographic Imaging

HD 10/21/2018

MAG opposes legislation that would allow an APRN to order or interpret radiographic imaging unless delegated under a written clinical nurse protocol. Special Report 03.18, Appendix III)

360.982 Diagnostic Radiology

HD 10/17/2015

MAG opposes CMS authorizing nurse practitioners and certified nurse specialists to order, perform and interpret diagnostic radiology. Furthermore, APRNs should not be authorized to order advanced images, including but not limited to the following: CT, MRI, PET, Nuclear and Bone Scans. MAG finds that the costs to perform and interpret these scans continues to escalate and believes that if this authority is expanded beyond physicians, it could become a tremendous expense to all. (Special 04.15 Appendix III)

360.985 APRN Protocol Agreement

HD 10/20/2013

MAG opposes increasing the number of APRNs supervised by a physician greater than current law, which is four, pursuant to a protocol agreement. (Officer 01.13, Rec. 3; Reaffirmed 10/20/2018)

360.988 Nurse Anesthetists

HD 10/21/2012

MAG opposes any state legislation and/or regulatory action to expand certified registered nurse anesthetists (CRNA) scope of practice to authorize the provision of chronic pain management. (Res. 309C.12; Reaffirmed 10/21/2017)

360.992 Primary Care

BD 8/1/2000

MAG opposes nurse practitioners being titled as primary care providers. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015

360.995 Nurses' Training

HD 5/1/1997

MAG recommends that the State Board of Nursing pursue the development of standardized training curriculums and standardized competency examinations for nursing assistants. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

360.996 Prescriptive Authority --APNs

HD 4/1/1996

MAG fundamentally opposes independent prescriptive authority for advanced practice nurses. Physician supervision and oversight for using "protocols" is essential. (Reaffirmed 05/1999 and 05/2002; 10/13/07; 10/20/12; 10/21/2017)

360.999 Supervision of Nurses Definition

N/A 4/1/1980

Physician supervision of a nurse means that the physician is responsible for the medical acts performed by the nurse, acting in accordance with his prescription or instruction. The supervising physician or his physician designee must be available daily to examine his patient and must regularly and systematically review the medical care. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/21/2018

370
Organ Donation and Transplantation

370.996 Organ Donations and Transplants

HD 10/19/2019

MAG should raise public and professional awareness about the need for transplantable organs and tissues. MAG should address the need for transplantable organs and tissues in its communications (e.g., newsletter, website and social media and/or journal) at least once a year. MAG should encourage interagency cooperation and unified activity in increasing donations of transplantable organs. Special Report 3.19, appendix III

370.997 Organ Donation Protocols
HD 10/16/2010
MAG recognizes the importance of physician participation in the organ donation process and acknowledges organ donation as a specialized form of end-of-life care, Special Report 04.10, III (Reaffirmed 10/17/2015)

375
Peer Review

375.998 Physician Case Reviewers
HD 10/5/2008
Health insurance and managed care physician case reviewers shall be the same specialty and shall be licensed to practice medicine in Georgia. (Resolution 307C.08; Reaffirmed 10/20/2013; 10/20/2018)

375.999 Peer Review Protections
HD 5/19/2001
MAG supports the need for federal legislation that will afford enhanced protection of peer review information from disclosure. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

380
Physician Fees

380.999 Balanced Billing
HD 10/17/2009
The Medical Association of Georgia opposes any legislative attempts to prohibit the balanced billing of patients by non-contracted physicians. (Res. 305C.09; (Reaffirmed 10/2014; 10/2019)

385
Physician Payment

385.995 Bundled Payments
HD 10/16/2011
MAG opposes payment models that support reductions in physician payments based on cost not directly attributable to that physician unless the physician knowingly enters into an agreement to accept such a payment model. (Res. 110A.11) (Reaffirmed 10/15/2016)

385.996 Payment System Framework
HD 10/17/2009
MAG endorses any payment system that meets the following criteria: 1) Encourages the development of both patient and physician responsibility, trust, and mutual respect; 2) Increases patient awareness in the reimbursement process; 3) Offers freedom for their services, as well as the method of payment they deem acceptable; and 4) Offers freedom of patients to select providers and their means of paying for the services they receive. (Special Report Appendix III; Reaffirmed 10/2014; 10/2019)

385.997 Billing and Payments
HD 10/13/2007
MAG opposes state legislation that dictates how a physician must bill for medical services, that inhibits fair market contracting between physicians, and that inhibits physicians from freely practicing medicine within acceptable professional standards. MAG opposes any state legislation that limits billing and payment for a defined medical services or group of services to a single medical specialty. (Res. 215.C.07; Reaffirmed 10/20/12; 10/21/2017)

390
Physician Payment: Medicare

390.983 Payment Mechanism
HD 10/16/2011
MAG opposes Medicare's new bundled payment models and initiatives which include 1) Centers for Medicare and Medicaid Services (CMS) and providers setting a target payment amount for a defined episode of care; 2) CMS to link payments for multiple services patients receive during an episode of care and 3) an entire team of physicians, and hospitals are compensated with a "bundled payment." (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

390.984 Medicare Mandated Assignment
HD 10/17/2009
MAG opposes legislation requiring mandatory assignment of Medicare benefits. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

390.985 Payment Formula
HD 10/13/2007
MAG and the AMA will continue to work with the U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services to ensure the correctness of the formula calculations for Medicare payment. (Committee 01.07, Attachment III; Reaffirmed 10/20/12; 10/21/2017)

390.990 Private Contracting and Means Testing
HD 5/1/1995
MAG supports Medicare laws that allow private contracting between physicians and patients; MAG supports removing Medicare definitions of allowable charges; MAG supports a plan of differential reimbursement for Medicare recipients with the ability to pay. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

390.991 Hyperbaric Oxygen
EC 10/1/1994
MAG supports Medicare payments of hyperbaric oxygen services in physicians' offices. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

390.993 Telephone Consultations
HD 4/1/1991
MAG supports Medicare's reimbursement of telephone consultations. (Reaffirmed 05/2000; 10/5/2008;

10/20/2013; 10/20/2018)

390.996 Reimbursement Changes
HD 4/1/1987
MAG should continue to use its resources to keep physicians informed of the reimbursement changes occurring in Medicare and Medicaid and express strong opposition to those payment system changes that interfere with the efficient and high quality practice of medicine. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

405
Physicians

405.988 State Health in Georgia Government
HD 10/16/2011
MAG supports the position that only physicians should direct the state health department and its Board and that its office be maintained at a Departmental level immediately below the office of Governor. MAG supports having a close working relationship with the state and local public health departments in a way that complements each other's efforts in improving the health of the community. (Special Report: 04.11, Attachment III) (Reaffirmed 10/15/2016)

405.990 OB/GYNs As Primary Care Physicians
HD 10/4/2008
MAG takes the position that OB/GYNs are primary care physicians. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

405.991 Use of the Term Physician
HD 10/13/2007
The Medical Association of Georgia supports legislation that limits the identification of a person as a physician only to individuals licensed under the Medical Practice Act. The Medical Association of Georgia urges the Composite State Board of Medical Examiners to enjoin the unlawful use of the term "physician" and/or "doctor" and will assist the Composite State Board of Medical Examiners in its efforts to enjoin the unlawful uses of these terms. (Res. 310C.07, Resolves 1-3; Reaffirmed 10/20/12; 10/21/2017)

405.992 Advertising
HD 10/16/2010
MAG opposes the use of the term "physician" by those not licensed to practice medicine, Special Report 04.10, III (Reaffirmed 10/17/2015)

405.996 Definition of Physician
BD 9/1/1993
MAG supports restriction of the word physician to only those persons licensed by the Composite State Board of Medical Examiners. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

405.999 Doctor -- Use of Title
HD 4/1/1979

MAG supports requiring all persons who use the term "Doctor" or "Dr." to designate the degree to which he is entitled. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

406
Physician Specific Health Care Data

406.977 Data Collection -- Clearinghouse
HD 10/17/2009
MAG believes that any health care data collection system should be primarily directed toward education, both for consumers and providers; MAG supports a statewide clearinghouse within Georgia's state health programs which are available for website access by the public. (Special Report, Attachment III; Reaffirmed 10/2014; 10/2019)

415
Preferred Provider Arrangements

415.996 Direct Primary Care -- Regulations
HD 10/18/2015
MAG supports state legislation that amends Georgia laws governing insurance regulations and physician licensure that will eliminate unnecessary impediments to the offering of direct primary care arrangements including legislation that permits physicians to contract as direct primary care providers to not be considered “risk bearing entities,” thus excluding them from insurance licensure and insurance regulation requirements. (Res. 303C.15)

415.997 Credentialing
HD 10/13/2007
MAG asserts that any physician meeting the overall credentialing criteria applied to all other providers and agreeing to the same method of payment be accepted into any health plan network to provide medical care. (Committee 01.07 Attachment III; Reaffirmed 10/20/12; 10/21/2017)

420
Pregnancy

420.994 Insurance Coverage
HD 10/17/2009
MAG supports coverage for newborn sickness, pregnancy complications, or pre-existing conditions. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

420.995 Prenatal Care
HD 4/1/1992
MAG supports outreach efforts for maternal and infant care to increase early registration for prenatal care. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

420.997 Funding -- Indigent Care
HD 4/1/1983
MAG supports the funding for care of the indigent and medically indigent mothers and infants in Georgia. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

420.998 High Risk Patients
HD 4/1/1983
MAG supports development of care for high-risk mothers and premature newborn infants. This should be accomplished in a manner that follows normal referral patterns which may or may not comply with designated health areas but protects the well-being of the patient. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

420.999 Family Planning Service
EC 8/1/1982
MAG supports the position that every pregnancy should be wanted and planned, and family planning services should be accessible to anyone who desires them. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

425
Preventive Medicine

425.996 Meningococcal Vaccinations
HD 10/22/2017
MAG supports evidence based meningococcal vaccinations for children, adolescents, and adults as recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control (CDC). (Res. 309C.17)

425.997 Expedited Partner Therapy
HD 10/18/2015
MAG supports expedited partner therapy in Georgia to help combat the spread of sexually transmitted diseases. (Res. 111.15)

425.998 Early Intervention Programs
HD 10/16/2011
MAG supports and promotes the development of early intervention and disease prevention programs at the national, state and local levels, including the mission, goals, and health indicators outlined in the U.S. Health and Human Services Department's "Healthy People 2020 Plan," Georgia's Medicaid and Care Management Program initiatives, and the Georgia Department of Public Health's 14 Health Promotion and Disease Prevention programs including: 1) the Adolescent Health and Youth Development program, 2) the Asthma Control program, 3) the Breast and Cervical Cancer program, 4) the Cancer State Aid program, 5) the Cardiovascular Health Initiative, 6) the Comprehensive Cancer Control program, 7) the Diabetes Prevention and Control program, 8) the Live Healthy Georgia program, 9) the Nutrition and Physical Activity Initiative program, 10) the Rape Prevention and Education program, 11) the Stroke and Heart Attack Prevention program, 12) the Tobacco Use Prevention program and 13) the Women's Health Medicaid program and 14) Worksite Wellness program. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

430
Prisons

430.995 Sexual Transmitted Disease Protections
HD 10/17/2010
MAG supports legislation that would allow any nonprofit or public health care agency to distribute sexual barrier protection devices to inmate. Distribution of such devices shall not be considered encouraging sexual acts between inmates and possession of such devices by inmates shall not be considered subject to the inmates' criminal or administrative sanctions (Res. 105A.10; Reaffirmed 10/17/2015)

430.997 Tobacco Use in Prisons
HD 5/1/1995
MAG supports the Georgia Department of Correction's commitment to cessation of the use of all tobacco products by staff and inmates in all of its facilities. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

435
Professional Liability

435.992 Tort Reform
HD 10/13/2007
MAG aggressively supports meaningful tort reform at the state and national levels. (Committee. 01-07, Attachment III; Reaffirmed 10/20/12; 10/21/2017)

435.995 Collateral Source
HD 5/4/2002
MAG supports collateral source legislation that will enable the defendant to inform the jury about the plaintiff's access to funds that will pay for the plaintiff's damages, such as his or her health insurance or other insurance proceeds. (Special Report: 3-02; Reaffirmed 10/2002; 10/2007; 10/20/12; 10/21/2017)

435.998 Antitrust Relief
HD 4/1/1994
MAG supports passage of a constitutional amendment allowing for physician antitrust relief. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

435.999 Alternative Dispute Resolution
HD 4/1/1993
MAG supports legislation that will enable the resolution of medical malpractice claims by various recognized forms of Alternative Dispute Resolution. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

440
Public Health

440.975 Coal-Fired Power Plants

HD 10/16/2011

MAG supports state government and utilities efforts to develop comprehensive energy efficiency standards of businesses, homes, appliances, and building construction prior to approving new coal-burning power plants; MAG recommends that careful consideration and full public debate be given to the least polluting options. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

440.976 Tanning Beds

HD 10/17/2009

MAG will work through appropriate channels to urge the AMA and the state of Georgia to use the World Health Organization rating that indoor tanning is of the same class of carcinogen as asbestos and tobacco in order to protect the public from the dangers of indoor tanning, specifically supporting the following: a) a ban on use of tanning beds by minors; b) signed consent forms that specify the risk of melanoma and other forms of skin cancer for users of indoor tanning; and c) a ban on calling indoor tanning "safe." (Resolution 105A.09; Reaffirmed 10/2014; 10/2019)

440.977 Defibrillators for Police

HD 10/17/2009

MAG supports all efforts to equip police with Automatic External Defibrillators (AED) and the training of police officers in the proper use of AEDs. (Resolution 104A.09; Reaffirmed 10/2014; 10/2019)

440.979 Public Health Support

HD 10/17/2009

MAG supports the continuation of state health programs that deal with critical issues involving domestic violence, child abuse, infant mortality, immunization of children and AIDS education. (Special Report: Attachment III; Reaffirmed 10/2014;10/2019)

440.982 Bioterrorism Planning

HD 10/15/2005

MAG will work in conjunction with federal and state agencies to coordinate plans and strategies with MAG membership, local medical societies and hospitals to deal with protecting individuals from the dangers of terrorism and natural disasters to our nation and to the state of Georgi, Comm. 01-05 Attachment III (Reaffirmed 10/16/2010; 10/17/2015)

440.983 Health Department Funding

HD 5/19/2001

MAG supports the monitoring of the impact of "revenue maximization" in the state's Health Department funding on the local health departments and if "revenue maximization" proves to result in reduced funding for the local health departments, that MAG seek to secure funding of the local health departments to levels sustained prior to implementation of "revenue maximization". (Res. 311C.01; Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

440.991 Immunization and Vaccination

HD 4/1/1994

MAG opposes the efforts of any health care provider that tries to discourage routine immunizations of children; MAG should work, both individually and collaboratively with other groups to promote public education campaigns encouraging immunizations of children. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

440.992 Tanning Facilities Regulations and Education

HD 4/1/1993

MAG encourages the enforcement of the current state laws regulating tanning facilities; and recommends that the appropriate regulatory bodies should, wherever possible, tighten and strengthen their regulations regarding tanning facilities; and, in conjunction with the Georgia Society of Dermatology, MAG will endeavor to educate physicians and the public regarding the dangers of tanning and tanning facilities. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

440.996 Hepatitis B Virus Immunization

HD 4/1/1987

MAG believes that physicians, in proposing prophylaxis with either the plasma-derived or the recombinant DNA Hepatitis B vaccine, include in their consideration, persons in susceptible preexposure categories, including, but not limited to, health care personnel, homosexual men and women with multiple sex partners and other high-risk groups. (Reaffirmed 05/2000; 10/2009; 10/2014;10/2019)

445
Public Relations

445.998 Clinical Medicine Public Education and Inquiry

HD 10/17/2009

Although the Medical Association of Georgia may comment from time to time on various matters relating to the treatment of disease and/or the maintenance of health, the public may best access medical information on the state's public health, CDC and HHS websites. Other more detailed information may be sought on the AMA website or that of other national medical specialty societies. The Medical Association of Georgia publicly endorses and supports this approach as the most appropriate way to serve both the public need for information and the need to maintain the highest possible level of objective scientific integrity. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

450
Quality of Care

450.985 Cannabis for Medical Use

HD 10/22/2017

MAG opposes the expansion of the legalization of non-standard and non-FDA approved use of cannabis for medical use in Georgia, and supports educating physicians and other clinicians on the risks of artisanal cannabis products lacking FDA approval. (Res. 602S.17)

450.986 Facilities denial to Physicians

HD 10/18/2015

MAG supports legislation asserting that medical centers should not be allowed to deny a licensed Georgia physician the ability to utilize its facilities as this denial is limiting the physician’s ability to practice medicine and to provide the best medical care to their patients. (Res. 312.15)

450.987 Veterans Affairs -- Enhanced Communication

HD 10/18/2015

MAG supports enhanced communications between patients' Veterans Affairs (VA) physicians and their other non-VA treating physicians using electronic and/or telephone, electronic medical records, and communication systems. (Res. 114A.15).

450.988 Choosing Wisely Program

HD 10/19/2014

MAG supports the concepts of the American Board of Internal Medicine Foundation's "Choosing Wisely" program as recommended by the American Medical Association. (Res. 103A.14) (Reaffirmed 10/2019)

450.989 Medical Treatment Guidelines

BD 04/21/2012

MAG supports the following medical treatment guidelines: 1) that clinical guidelines are intended as general clinical information for reference to promote best practice and are not to be construed as rules, nor are they to become proxies for the standard of care. We support the traditional professional perspective of the physician as the sole and final medical decision-maker in medical treatment; 2) Clinical guidelines must be constructed and adopted based on a broad consensus of opinion from actively practicing physicians and relevant physician organizations, free of conflict of interest. Effective mechanisms shall be established to ensure opportunities for input; 3) Clinical guideline adoption is based on an affirmative vote or similar action by the majority of the physicians for whom the guideline is intended; 4) Clinical guidelines shall be adapted at the local/state/regional level, as appropriate to account for various factors, including demographic variations, patient case mix, availability of resources, and relevant scientific and clinical information; 5) Clinical guideline adoption by individual physicians will not be used as the sole exclusion criterion for any third party payer unless the physician is employed or under contract with an entity that chooses to comply with guidelines; 6) Physician compensation should not be based upon adherence to clinical guidelines; 7) Clinical guidelines implemented at the local/state/regional level shall acknowledge the ability of physicians to depart from the recommendations in clinical guidelines, when appropriate, in the care of individual patients. The physician's rationale for a change in treatment should be appropriately documented; and 8) Published materials on the use of clinical guidelines should be fact-based and accurate concerning their "true effect." (Reaffirmed 10/21/2017)

450.991 Clinical Practice Guidelines

HD 10/13/2007

MAG believes that clinical guidelines are not a substitute for the experience and judgment of the physician; MAG recommends to all specialty and subspecialty societies and others that this reaffirmation be included as an addendum to each clinical guideline. (Reaffirmed 10/20/12;10/21/2017)

450.996 Peer Review Grievances

HD 10/16/2010

MAG supports physician peer review systems that are fair and equitable and allow for resolution of grievances. (Special Report 04.10, III; Reaffirmed 10/17/2015)

460
Research

460.996 Stem Cell

HD 10/17/2010 MAG supports ethical stem cell research including hESC, (Res. 303C.10; Reaffirmed 10/17/2015)

460.997 Medical Use of Lab Animals

HD 4/1/1992
MAG supports the availability of factual information to all component medical societies and medical schools for the media and the public to confront the distortions concerning medical use of laboratory animals presented by many animal rights activist groups. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

460.998 Inclusion of Women in Research

HD 4/1/1991
MAG encourages the inclusion of women in all research on human subjects, except in those cases where it would be scientifically irrational, in numbers sufficient to ensure that the results of such research will benefit both men and women alike. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

460.999 Marijuana -- Cancer Treatment

HD 10/19/2019
MAG strong condemns the use of marijuana and any of its cannabinoid derivatives such as delta9tetrahydrocannabinol (THC) for general (recreational) use. (Special Report 3.19, appendix III)

470
Sports and Physical Fitness

470.986 Coaches -- Youth Sports

HD 10/20/2019
MAG supports the concept of certification of youth sports coaches in and outside of school athletic programs with a focus on practices to minimize participation injuries, prevention of heat illness, and appropriate management of concussion. (Res. 304C.19, Resolve 1)

470.987 Visiting Sport Team Physicians

HD 10/16/2016
MAG supports legislation that protects visiting athletes by providing limited exemption of licensure for visiting team physicians who are licensed in their home state, to care for visiting athletes, coaches, and support staff while participating in sporting events within the state of Georgia. (Res. 305C.16)

470.988 Heat Injury Prevention

HD 10/18/2014
To minimize heat injuries in all sports, the following points should be followed: 1) Players should have unlimited access to water; 2) in hot weather, practices should be held in the "two-a-day" format (once early in the morning and once late in the afternoon); 3) Coaches should take advantage of continuing education opportunities to keep themselves current in recognizing and treating heat injuries; and 4) School systems should make available qualified athletic trainers to coaches and players in the system. Special Report 4, Attachment III) (Reaffirmed 10/2019)

470.989 State Boxing Commission Rules

HD 10/18/2014

MAG believes the State Boxing Commission should include the following points in its rules: a) the ringside physician should have the authority to stop a match if, in his/her medical judgment, continuation would result in death or serious injury to either contestant; b) a physician, possessing an unlimited license to practice medicine and surgery in Georgia, should act as a consultant to the Commission as needed; c) the Commission should require that any contestant who is knocked out undergo an appropriate neurological examination by a licensed medical doctor ; and d) any professional boxer, as a condition of licensure, should be required to disclose to the Commission all medical records relating to treatment of any physical condition which relates to his/her ability to fight. (Special Report 4, Attachment III) (Reaffirmed 10/2019)

470.990 Steroids -Use By High School Athletes

HD 10/17/2009

MAG urges all Georgia junior high and high schools to be aware of the dangerous side effects of the use of steroids. Printed materials and/or seminars conducted for athletes, coaches and parents are available at various locations. (Special Report: Appendix III) (Reaffirmed 10/2014;10/2019)

470.993 Boxing

HD 1/1/1987

MAG supports elimination of both amateur and professional boxing, a sport in which the primary objective is to inflict injury. (Reaffirmed 05/2000; 10/2009; 10/2014;10/2019)

470.995 Medical Evaluation

EC 8/1/1985

MAG believes that an unconscious athlete must have a medical evaluation by a licensed medical doctor. The athlete should not be allowed to return to the same contest in which he/she was rendered unconscious. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

470.997 Horseback Riding Safety

HD 8/1/1984

MAG promotes the need for educational programs to be given to parents, riding instructors, show organizers and managers outlining the risks of horseback riding and methods to minimize those risks. MAG recommends that, where appropriate, satisfactory protective headgear should be selected for each type of riding activity and worn when riding or preparing to ride. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

490
Tobacco

490.990 Smoking by Coaches

HD 10/18/2014

MAG urges coaches, in their role as leaders, to restrict their own and their team smoking. (Special Report 4, Attachment III) (Reaffirmed 10/2019)

490.992 Smoking
HD 5/4/2002
MAG supports legislation that increases the legal age to buy tobacco in Georgia to 21 and increases fines and enforcement efforts to prevent exposure of adolescents to cigarettes. (Res. 310C.02; Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

490.994 Tobacco Smoke
HD 5/1/1998
MAG recognizes that environmental tobacco smoke is a major threat to public health, and endorses legislation by the state of Georgia to stop or severely limit the use of tobacco in all public buildings and enclosed work areas in the state, Resolution 302C-98) (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

490.995 Tobacco Subsidies
HD 4/1/1993
MAG supports the AMA's efforts to petition the U.S. Congress to end its subsidy of the tobacco industry. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

490.996 Smoke-Free Environments
HD 4/1/1992
MAG supports enactment of public smoking restrictions and urges local medical societies to become active in educating their communities about the health hazards of secondhand smoke. MAG also encourages businesses and individuals to provide smoke-free environments for their employees and families. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

490.997 Tobacco Use -- Cause of Death
HD 4/1/1989
MAG encourages physicians to list tobacco on Georgia death certificates as a contributing factor to the cause of death, when appropriate. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

490.999 Smoking Opposition
HD 4/1/1983
MAG urges physicians to eliminate cigarette smoking as a personal habit, and also urges smoking to be eliminated from all medical and health-related facilities. MAG actively promotes cessation of smoking among patients and staff. MAG should use its influence to enact anti-smoking legislation within local communities and with health-related professionals to gain their cooperation in anti- smoking efforts. MAG opposes any smoking in any MAG meeting and at MAG headquarters. MAG encourages county medical societies to initiate and support efforts to reduce smoking and othersubstance abuse in local schools. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

500
Tobacco: Marketing and Promotion

500.989 Tobacco in Youth-Related Movies
HD 10/20/2013
MAG opposes the use of tobacco products in youth-related movies and supports all efforts to eliminate such props in films. (Special Report 04.13, Attachment III; Reaffirmed 10/20/2018)

500.999 Tobacco Advertising
HD 4/1/1989
MAG opposes tobacco advertisements in the media. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

505
Tobacco: Prohibitions on Sale and Use

505.997 Cigarette Excise Tax
HD 4/1/1987
MAG supports an increase of the federal excise tax on cigarettes with the provision that income from this additional taxation be earmarked as revenues for Medicare. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

505.998 Tax on Tobacco
HD 10/5/2008
The Medical Association of Georgia supports increases in the state tobacco tax as a means of reducing tobacco use. (Resolution 309C.08) (Reaffirmed 10/20/2013; 10/20/2018)

505.999 Tobacco Sale to Minors
BD 1/1/1987
MAG supports the prohibition of the sale of tobacco products to minors. (Reaffirmed 05/2000;10/2009; 10/2014; 10/2019)

515
Violence and Abuse

515.994 Sexual Assault Guidelines
HD 10/17/2009
MAG supports the use of Sexual Assault Guidelines issued by both the American College of Obstetricians & Gynecologists and the American College of Surgeons as modified to conform with Georgia laws for use as a model by hospital emergency rooms and rape crisis centers throughout Georgia. (Special Report: Appendix III) (Reaffirmed 10/2014; 10/2019)

515.995 Adult Abuse
HD 10/15/2005
MAG supports the legal protection of disabled adults from physical abuse. Civil and criminal immunity should be provided to those who report in good faith cases of adult abuse. (Comm. 01-05 Appendix III; Reaffirmed 10/16/2010; 10/17/2015)

515.997 Sex and Violence
HD 10/16/2010
MAG condemns the expression of excessive violence and sex on television, radio, the internet and other common means of communication and encourages its members to work with appropriate groups to lessen

the broadcasting of and the impact of their detrimental effects on our society, Special Report 04.10, III (Reaffirmed 10/17/2015)

515.998 Battered Women Information

BD 6/1/1989

MAG supports disseminating to all members information on the recognition and treatment of battered women, including statewide referral support systems. (Reaffirmed 05/2000;10/2009; 10/2014; 10/2019)

525
Women

525.996 Womens Health Care

HD 10/21/2012

To preserve quality health care for women, MAG shall: 1) oppose any legislation that violates the doctor/patient relationship; 2) oppose legislation that threatens criminal prosecution against physicians who diagnosis, prescribe and perform medical treatment within their scope of practice; 3) support women and couples who seek and receive fertility treatment and their decisions concerning embryos created as part of that treatment; and 4) support policies and legislation that allow women and families to maintain access to quality health care in Georgia. (Resolution 315C.12; Reaffirmed 10/21/2017)

525.997 Breastfeeding

HD 10/13/2007

MAG supports protection of a mother's right to breast feed in public and encourages all states to pass legislation that reaffirms the right to do so. (Committee 01.07, Attachment III; Reaffirmed 10/20/12; 10/21/2017)

530
MAG: Administration and Organization

530.880 Georgia Physicians Leadership Academy

HD 10/16/2016

MAG endorses the Georgia Physicians Leadership Academy as an integral program in training future and emerging leaders of medical societies in Georgia, and encourages present and future leaders of MAG and/or component society to enroll in a GPLA class...(Special Report 07.16)

530.881 Investment Policy--MEP 401k

BD 1/26/2013

MAG shall maintain a policy statement for its MEP 401(k) Plan that shall be kept at MAG Headquarters. (Reaffirmed 10/20/2018)

530.882 CMS Registration Fees

HD 10/16/2011

MAG shall waive any registration fee required at MAG functions and/or events to county medical executives. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

530.883 Student Travel Reimbursement

HD 10/16/2011

MAG supports the funding of two medical students to attend the AMA Annual meeting. Funds will be charged to the MAG Medical Student Section. Medical students shall be identified to the AMA Delegation and shall participate as directed by the Chair of the AMA Delegation. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

530.885 Investment Policy

HD 10/17/2009

The MAG Board of Directors shall adopt an Investment Policy consistent with the goals of accumulation of capital and the preservation of its value for the economic betterment of MAG. (Special Report: Appendix III) (Reaffirmed 10/2014; 10/2019)

530.886 Policy Guidelines -- Sunset

HD 10/17/2009

The Board of Directors shall submit to the House of Delegates annually a list of MAG policy statements, which in the opinion of the Board no longer serve the best interest of the Association. The presence of policy statement on the list shall be a clear indication that such statement is no longer the policy of the Association, unless by action of the House, they are removed from the list. (Special Report, Attachment III) (Reaffirmed 10/2014; 10/2019)

530.887 Balanced Budget

HD 10/17/2009

The Board of Directors shall approve a balanced annual operating budget. (Special Report: Appendix III) (Reaffirmed 10/2014; 10/2019)

530.888 Specialty Societies Recognition

EC 1/23/2009

MAG shall adhere to the following guidelines for recognizing state specialty societies: 1) The MAG Board of Directors may, by a majority vote, recognize certain state specialty societies for the purposes of seating in the House of Delegates, the Council on Legislation and other purposes as specified in the Bylaws; 2) A “specialty” should represent a field of medicine that has recognized scientific validity. A clearly defined subspecialty of internal medicine or surgery may be regarded as a distinct specialty. A specialty must be recognized by the American Board of Medical Specialties; 3) It is desirable, but not necessary, that a specialty society have a relationship to a national specialty society; 4) An applying specialty society should not already be represented within MAG by other societies. In those cases in which multiple societies exist in a single specialty field, representation in MAG should be granted to the society that has a relationship with a national specialty society. If more than one society has a relationship with a national specialty society, representation in MAG may be shared by having societies alternate in voting privileges at meetings. Ultimately, the MAG Board of Directors determines which state specialty society will represent the physicians of that specialty. Notwithstanding the foregoing, no specialty society with representation in MAG on January 1, 2009 shall forfeit such representation as it then existed as a result of this paragraph; 5) Physicians should comprise at least 75 percent of the active voting membership of the specialty society; 6) A specialty society should be established and stable. It should have been in existence in Georgia for at least two years, have a formal leadership and membership structure, and conduct at least one meeting per year; 7) A majority of the physician members of the specialty society should be practicing within the field of the specialty; 8) Specialty society representatives must be MAG members. The specialty society representatives shall work diligently to increase its specialty society’s membership in MAG; 9) Specialty society representatives will be accountable for the

same attendance and participation requirements as all other MAG members; and 10) Specialty society delegates to the MAG House of Delegates should be elected by their sponsoring societies.(Reaffirmed 10/2014; 10/2019)

530.890 Executive Committee Travel

HD 10/4/2008

Travel to meetings of the Executive Committee during the weekend meetings of the Board of Directors are not eligible for reimbursement. (Special Report 05.08, attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

530.891 JMAG Subscriptions

HD 10/20/2018

MAG will maintain the MAG Journal subscription cost of $120 per year for international subscriptions. (Special Report 3, III)

530.893 Physician Payments (Use of Term)

EC 4/13/2007

MAG shall, in all of its communications and publications, use the term "physician payment" in lieu of "physician reimbursement." (Reaffirmed 10/20/12; 10/21/2017)

530.895 Physician Lobbying

HD 9/30/2006

MAG shall coordinate trips to Washington, D.C. for the purpose of convening in a unified manner, our concerns about health care legislation to our Congressional Delegation. (Reaffirmed 10/16/2011; 10/15/2016)

530.896 Membership List/Labels

HD 9/30/2006

MAG shall maintain a membership list and labels policy that defines its purpose, use, and composition and billing and purchasing rules. (Reaffirmed: 10/16/2011; 10/15/2016)

530.897 Legislative Involvement

HD 9/30/2006

MAG will provide meaningful opportunities for physicians to participate in educating legislators, to improve their understanding of the practice of medicine, as government continues to impact all facets of the modern day practice of medicine; MAG urges all physicians to participate in such projects and programs conducted through MAG's legislative department. (Reaffirmed 10/16/2011; 10/15/2016)

530.898 Employee Contracts

HD 9/30/2006

MAG shall maintain an employment policy that includes conducting annual reviews of all employees. (Reaffirmed 10/16/2011; 10/15/2016)

530.909 Guest Attendance at MAG Events

BD 1/28/2006

Non-members and non-physicians (i.e., county medical society executives, MAG Mutual, Georgia Medical Care Foundation, Georgia Hospital Association) may be invited to attend events and/or functions of the Medical Association of Georgia at the discretion of the physician leader whose duties hold

jurisdiction over the event and/or function. Information and materials related to the event and/or function will be provided to a guest only by order of the physician leader. All other matters pertaining to sharing information not referenced herein shall be left to the discretion of MAGPresident and/or Executive Director. (Reaffirmed 10/16/2011; 10/15/2016)

530.911 Travel Reimbursement

HD 10/16/2010

The Board of Directors will maintain a written policy on reimbursement of travel expenses for the AMA Delegation and the Executive Committee. (Special Report 04.10, III; Reaffirmed 10/17/2015)

530.912 Endorsements of Products

HD 10/16/2010

MAG shall have an internal business policy. It may endorse products and/or services from outside vendors provided a risk analysis is done prior to such endorsements, Special Report 04.10, III (Reaffirmed 10/17/2015)

530.913 Conflict of Interest

HD 10/16/2010

MAG will have in place a Conflict of Interest Policy for elected officers, directors and senior staff who shall sign such policy annually and copies shall be maintained by the General Counsel, Special Report 04.10, III (Reaffirmed 10/17/2015)

530.914 Members Only Web Pages

HD 10/16/2010

MAG shall develop member-only pages on the MAG Website on a select basis to provide members with easy access to password-protected information, Special Report 04.10, III (Reaffirmed 10/17/2015)

530.919 Destruction of Documents

EC 2/25/2005

In compliance with the Sarbanes-Oxley Act, the Medical Association of Georgia's document retention policy will include the following statement: Federal law prohibits knowingly altering, destroying, mutilating, concealing, covering-up, falsifying, or making a false entry to any record document or tangible object with the intent to impede obstruct or influence the investigation or proper administration of any matter within the jurisdiction of any department or agency of the United States, or any case filed under the bankruptcy laws or in relations or contemplation of any such matter or case. Employees are instructed to advise the General Counsel when they believe compliance with MAG's record retention policy would violate this federal law. (Reaffirmed 10/16/2010; 10/17/2015)

530.920 Whistle Blower

EC 2/25/2005

In compliance with the Sarbanes-Oxley Act, the Medical Association of Georgia will not retaliate against any employee for providing a law enforcement officer as defined in the American Competitiveness and Corporate Accountability Act (The Sarbanes-Oxley Act) with any truthful information relating to the commission or possible commission of any federal offense. (Reaffirmed 10/16/2010; 10/17/2015)

530.922 Branding

HD 8/22/2003

MAG should continue to develop and implement a cohesive brand image to promote the association and reinforce its message and image. (Report 15AB.03,Rec. 2) (Reaffirmed 10/5/2008; 10/20/2013;

10/20/2018)

530.924 Technology Communications

HD 8/22/2003

MAG will continue to enhance its communications with physicians by improving on current methods, developing the use of new technology, and encouraging continued and expanded use of e-mail updates of MAG activities. (Committee 18F.03) (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

530.925 Advocacy Activities

HD 8/22/2003

MAG continues to place its greatest emphasis on advocacy activities for patients and physicians. These activities should include an emphasis on issues related to quality of care, reimbursements and costs of practice (Committee 18F.03) (Reaffirmed 10/5/2008; 10/20/2013; 10/21/2018)

530.927 Educational Programming Delivery

HD 8/22/2003

MAG should continue to develop and implement innovative ways in delivering educational programming to physicians. (Committee 18F.03) (Reaffirmed 10/5/2008; 10/20/2013; 10/2018)

530.930 Stationery and Logo (MSS and YPS)

EC 8/2/2002

The approved logo for the Medical Student Section and the Young Physician Section shall be kept at MAG headquarters. Written communications from the Medical Student Section and Young Physician Section shall be generated at MAG headquarters and such communications shall include MAG's name on the letterhead. (Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

530.932 MAG Directory

HD 5/4/2002

MAG supports development of usable, complete and accurate membership/resource directories produced electronically. (Special Report: 3-02, Rec. 4; Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

530.936 Actions of AMA Meetings

HD 5/19/2001

MAG, at the conclusion of the AMA Annual and Interim meetings, will communicate to its members the actions taken by AMA. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

530.940 Personnel Policies

HD 10/16/2010

MAG shall have a written employee manual of office policies and job descriptions for all employees Special Report 04.10, III (Reaffirmed 10/17/2015)

530.946 Lawsuit Guidelines

HD 10/16/2010

MAG will utilize objective guidelines known as the Criteria for Case Selection when deciding whether to engage in a lawsuit as party or as a friend of the court. (Special Report 04.10, Attachment III; Reaffirmed 10/17/2015)

530.952 Policies

HD 10/16/2010

MAG will maintain a compendium of current policies of the association. The Policy Compendium will be available to all members on the MAG website In an effort to keep all policies up-to-date, an annual review shall be conducted of policies that are five years or older and recommendations will be presented to the House of Delegates to reaffirm, sunset or revise said policies, Special Report 04.10, III (Reaffirmed 10/17/2015)

530.959 AMA Nominations & Endorsements

EC 2/1/1997

MAG directs that all nominations to AMA first be addressed by the Georgia Delegation and then forwarded to the Executive Committee for association endorsement. In case of emergency, the President may authorize the association's endorsement. (Reaffirmed 9/30/2006; 10/16/2011; 10/16/2016)

530.963 Georgia Medical Group Management Association

EC 12/1/1996

MAG agrees to the appointment, as ex-officio members of MAG committees, the names submitted by the Georgia Medical Group Management Association, for a period of one year and upon acceptance by the chairmen of the requested committees. (Reaffirmed 05/2002;10/20/07; 10/20/12; 10/21/2017)

530.968 Policy Guidelines (Distribution and Modification)

HD 4/1/1996

MAG directs that all policy statements be maintained in a manner that will allow for easy distribution and modification to maintain a current reflection of MAG policies. (Reaffirmed 05/2002; 10/20/07; 10/20/12; 10/21/2017)

530.970 Communication

HD 4/1/1996

MAG continues to encourage communication with component groups and allied organizations in order to advance our common goals. (Reaffirmed 05/2002; 10/13/07; 10/20/12; 10/21/2017)

530.977 Association Name

BD 9/1/1994

MAG directs that the use of the association name or financial assistance for any conference or activities must be approved by the Board of Directors, or in the interim, the Executive Committee. In case of emergency, the President may authorize the use of the Association's name. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

530.978 MAG Journal Evaluations

HD 4/1/1994

MAG's Board of Directors should continue to constantly evaluate the Journal and its Editor, but not set a specific term of service for the Editor. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

530.982 Limiting Handout Materials

EC 4/1/1993

MAG shall eliminate excessive materials to the Executive Committee and Board of Directors. No handouts may be presented to either body unless first approved by the Executive Director and by the approval of either the President or Chairman of the Board. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013;

10/20/2018)

530.984 Staff Salaries

EC 8/1/1992
MAG Executive Director shall have the ultimate authority to establish the salaries of all other MAG staff; the Finance Committee and the Executive Committee will not micromanage this area. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

530.992 Contractual Practice

HD 4/1/1988
MAG should monitor corporate and contractual medicine developments in the state. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019

530.999 Appropriate Nomenclature for Physician

HD 4/1/1978
MAG refrains from the use of the term "provider agreement" as well as "health care professionals, providers and consumers" when referring to physicians, the practice of medicine, medical care and patients. Also, MAG should encourage third party payers to limit the use of the term "medical staff"to apply only to physicians. In order to be consistent with that policy directive, all members of the staff should be alert not to use such terms in correspondence or other official memorandums. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

535
MAG: Board of Directors

535.980 Recruitment

HD 10/20/2012
Members of MAG's Board of Directors, as a condition of their position, are required to actively engage in membership recruitment and other membership efforts adopted by the Board. (Special Report Attachment III; Reaffirmed 10/21/2017)

535.981 Executive Committee Reports

HD 10/17/2009
MAG Board of Directors will approve all actions of the Executive Committee since the previous Board meeting. (Special Report: Attachment III) (Reaffirmed 10/2014; 10/2019)

535.982 CMS/Specialty Society Liaison

HD 10/17/2009
MAG member leadership and/or staff designated shall make a special effort to visit component medical and specialty societies upon request to relay information and to respond to concerns. (Special Report: Attachment III; Reaffirmed 10/2014; 10/2019)

535.983 Voting Privileges

HD 10/17/2009
The bylaws of all MAG-related entities should assure that the President and Treasurer of the Medical Association of Georgia are designated as full voting members of each respective Board of Directors and that the Executive Director be seated as a member of each respective entity's Board of Directors with

voting privileges to be determined by the respective Boards. (Special Report: Attachment III; Reaffirmed 10/2014; 10/2019)

535.984 Component Society Meetings

BD 7/28/2007

Members of the MAG Board of Directors should attend meetings of the component medical societies and specialty medical societies in their areas, and promote MAG membership at these meetings; members should work with MAG staff to obtain a pre-registration list of attendees at specialty society meetings in order to target non-MAG members while attending the meeting. (Reaffirmed 10/20/12; 10/21/2017)

535.989 Conflict of Interest

BD 8/1/2000

MAG directors and officers have a duty to discharge their duties in a manner that he/she believes, in good faith, to be in the best interest of the association and with the care an ordinary prudent person in like position would exercise under similar circumstances. Directors and officers shall disclose a conflicting interest respecting a transaction effected or proposed to be effected by the Association. A conflict of interest exists if such director or officer is a party to the transaction or has a beneficial interest in or so closely linked to the transaction and is of such financial significance to the director, officer or person related to such director or officer that it would reasonably be expected to exert an influence on the director's or officer's judgment. A "person related to such director or officer" means the spouse (or a parent or sibling thereof) of the director or officer or a child, grandchild, sibling, parent (or spouse of any thereof) or any individual having the same home as the director or officer, or a trust or estate of which such an individual is a substantial beneficiary. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

535.990 Invitations to Attend

HD 5/1/2000

At the discretion of the Board Chairman, invitations to the meetings of the Board of Directors may be sent to non-MAG members. Comm: 3-00, Rec. 7; Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

535.992 Board Orientation Session

HD 10/16/2010

MAG will conduct an orientation session for new Board members explaining their duties and responsibilities as members of the Board of Directors as well as acquaint them with the structure and operations of the association. New board members are to attend such orientations, Special Report 04.10, Attachment III (Reaffirmed 10/17/2015)

535.993 Lawsuits

BD 1/1/1998

If the Board enters into a lawsuit where no line item is allocated, the Board will state from where in the budget funds are to be taken. (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

540
MAG: Councils and Committees

540.946 Council on Legislation -Appointing Vice Chairmen

EC 8/2/2015

Vice chairmen of the Council on Legislation shall be recommended by the president and approved by the

Executive Committee.

540.947 External Appointed Members

EC 7/27/2014

MAG shall expect that all external appointed members attend at least two MAG meetings each year during the course of their appointments. (Reaffirmed 10/2019)

540.948 Council on Legislation -- Improving Relations

BD 5/3/2014

MAG Council on Legislation shall meet every other week during the legislative session, and three times following the legislative session before the end of each calendar year. (Reaffirmed 10/2019)

540.949 Correctional Medicine

HD 10/20/2018

MAG's Correctional Medicine Committee is established to "study and recommend ways to improve the delivery and promote the availability of adequate professional health care in Georgia's prisons and jails." The committee shall provide resources to assist physicians and other health care providers within correctional facilities to meet standards of professional health care as determined by the American Medical Association, the National Commission on Correctional Health Care and this committee, and to provide those who meet such standards with recognition in the form of accreditation. This committee shall have responsibility for liaison with appropriate state agencies, organizations and other MAG committees in achieving these objectives and shall serve as a resource for physicians who provide care to inmates. The program is funded through the Georgia Department of Corrections (GDC) and the counties who wish their facilities accredited. (Special Report 3, III)

540.950 Journal Directives

HD 10/15/2016

The following directives regarding the MAG Journal shall be used: 1) The JMAG Editorial Board will be a strategic oversight group that meets four times a year or as needed to discuss editorial content and other applicable issues; 2) JMAG should strive to remain budget neutral or better; and 3) MAG Journal should be published on a quarterly basis and include a recap of MAG’s House of Delegates meeting each year that is supplemented by a detailed HOD meeting report which is printed as needed. The detailed HOD report will also be posted on www.mag.org so that all members can access the information. The Journal’s editorial content should address key issues that are pertinent to physicians, including MAG’s advocacy efforts in the legislative (state and national) and legal areas; MAG's subsidiaries; health policy; education/CME; third party payer (e.g., Medicare/Medicaid); county/member/specialty news; medical schools; and other case reports, etc. Standard Journal features will include messages from MAG’s president, executive director and editor. (Consent Calendar Appendix III)

540.951 Appointments

HD 10/4/2008

Members of Committees are appointed or reappointed at the Executive Committee meeting following the meeting of the House of Delegates. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

540.955 Legislative Programs and Activities

HD 10/16/2010

A physician's participation in MAG's physician legislative programs and activities should be considered as a factor when appointing members to serve on the Council on Legislation. MAG urges that members of

the Council on Legislation participate in the Doctor of the Day Program and become a member of GAMPAC, Special Report 04.10, III (Reaffirmed 10/17/2015)

540.956 Executive Committee Meetings

HD 10/16/2010

Members of the Executive Committee are expected to attend and participate in all meetings of the Executive Committee. The Chairman of the Executive Committee, at his/her discretion, may allow members of the Executive Committee to participate in executive sessions of the Executive Committee by teleconference, Special Report. 04.10, III (Reaffirmed 10/17/2015)

540.958 Legislative Priorities

HD 10/15/2005

MAG's Council on Legislation will develop and submit for approval a prioritized legislative agenda to the Board of Directors at its fall meeting each year. MAG's Legislative Department will also develop an agenda for relationship building and groundwork to be accomplished before the legislative session with emphasis on relationships with specialty societies and other aspects of organized medicine, Comm. 01-05 Attachment III) (Reaffirmed 10/16/2010; 10/17/2015)

540.959 MAG Foundation Financials

BD 10/25/2003

The Finance Committee shall review quarterly financial statements from the MAG Foundation; and shall invite the MAG Foundation Chairman to meet on an annual basis. (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

540.960 CME Committee -- Disclosure Policy

EC 7/13/2003

MAG's CME Committee shall adhere to: that all accreditation decisions be made in a fair and impartial manner. In the spirit of the Disclosure Policy that guides the design and offering CME events, the Committee establishes the following procedures: 1) upon the announcement of committee discussion of any accredited or unaccredited organizations, products or services, with which they have a present or past professional relationship i.e., staff privileges, CME committee membership, investment, policyholder, specialty society membership, one's own specialty and committee members are expected to announce that relationship; 2) At the discretion of the Chair, members may be asked to excuse themselves from discussion or vote on the matter in hand; and 3) Committee Minutes will reflect these disclosures. (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

540.961 Vice Chairmen

EC 5/16/2003

All committees shall have a designated vice chairman to assist each chairman in carrying out the duties assigned to the committees. (Reaffirmed 10/5/2008: 10/20/2013; 10/20/2018)

540.963 MAG MSS Fundraising Guidelines

EC 4/6/2003

MAG authorizes fundraising activities by the Medical Student Section provided that the following guidelines are as followed: 1) All checks shall be made payable to the Medical Association of Georgia and delivered to MAG; 2) Funds shall be kept in a dedicated account to be used exclusively by the MAG Medical Student Section to promote student involvement in MAG activities. The MSS Governing Council shall be authorized to direct spending from the account subject to the approval of the Executive Committee or the Executive Director of MAG. The MSS must turn in a written request for disbursements

detailing need for such funds; 3) The manner, method and target sources of solicitation shall be submitted to the Executive Director for approval prior to engaging in any solicitation. All letters sent should be generated from MAG headquarters with a copy of the mailing being kept on file at MAG headquarters; 4) Any fundraising activity must be accompanied by a full disclosure that the funds will be used for the exclusive use of medical students to participate in MAG activities, and 5) The Medical Student Section shall include in its annual report to the House of Delegates a description of all fundraising activities and an accounting of all revenue and expenditures. (Reaffirmed 10/5/2008; 10/20/2013; 10/20/2018)

540.966 Continuing Medical Education Committee

EC 4/7/2002

The Continuing Medical Education Committee shall accredit organizations that desire to offer CME activities to Georgia physicians. The CME Committee shall review and approve applications for accreditation and reaccreditations, establish accreditations policies, provide supervision and guidance to surveyors, hold training sessions for MAG-accredited sponsors and keep all sponsors updated concerning MAG, ACCME and AMA policies related to CME. (Reaffirmed 10/13/07; 10/20/12; 10/21/2017)

540.989 Finance Committee

HD 4/1/1996

MAG authorizes the Chairman of the Board of Directors, in consultation with the Treasurer, to appoint Finance Committee members to staggered two year terms. (Reaffirmed 05/2002; 10/2007; 10/20/12; 10/21/2017)

540.998 Council on Legislation -- Coordination of Efforts

HD 4/1/1988

Specialty groups and individual members should discuss proposed legislation with the Council on Legislation and the lobbyists/consultants for specialty societies should be encouraged to work with the MAG legislative staff for better coordination of efforts. (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

540.999 Council on Legislation Structure

EC 7/28/2006

The Council on Legislation shall be governed by a structure that will be attached to the MAG Master Committee Structure. (Reaffirmed 10/16/2011; 10/15/2016)

545
MAG: House of Delegates

545.943 Microphone Designation

HD 10/20/2019

MAG shall have at the House of Delegates one microphone designated for those in favor of a resolution and one microphone designated for those against a resolution. (Comm. 07.19, Rec. 3)

545.944 Debate -- Equitable Time

HD 10/20/2019

MAG’s Speaker of the House of Delegates shall establish equitable time constraints for debate, including time for both those for and against a resolution, for any resolution that is identified by the Speaker of the House or Executive Director to be an issue that may divide the members of MAG. (Comm. 07.19, Rec. 2)

545.945 Debate -- Balanced

HD 10/20/2019

MAG shall allow balanced and equitable debate before a motion to end debate is in order, and no debate shall be ended prematurely. (Comm. 07.19, Res. 1)

545.946 AMA Collaborative Intent

HD 10/16/2011

MAG adopts the following AMA Statement of Collaborative Intent as follows:

(1) The AMA House of Delegates endorses the following preamble of a Statement of Collaborative Intent: The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership. The goals of the Federation of Medicine are to: (a) achieve a unified voice for organized medicine; (b) work for the common good of all patients and physicians; (c) promote trust and cooperation among members of the Federation; and (d) advance the image of the medical profession; and (e) increase overall efficiency of organized medicine for the benefit of our member physicians and (2) The AMA House of Delegates endorses the following principles of a Statement of Collaborative Intent: (a) Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians. (b) Organizations in the Federation will be supportive of membership at all levels of the Federation. (c) Organizations in the Federation will seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation. (d) Each organization in the Federation of Medicine will actively participate in the policy development process of the House of Delegates. (e) Organizations in the Federation have a right to express their policy positions. (f) Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine. (g) Organizations in the Federation will support an environment of mutual trust and respect. (h) Organizations in the Federation will inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict. (i) Organizations in the Federation will support the development and use of a mechanism to resolve disputes among member organizations. (j) Organizations in the Federation will actively work toward identification of ways in which participation in the Federation could benefit them. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

545.947 Fiscal Impact of Resolutions

HD 10/17/2010

Resolutions submitted to the MAG House of Delegates beginning in 2011 shall include a statement from the author on the fiscal impact of said resolution will have on the association so as to allow delegates to fully evaluate its merit, Resolution 402C.10 (Reaffirmed 10/17/2015)

545.948 Meetings

HD 10/13/2007

Annual meetings of MAG should be held in late summer or early fall of each year. (Committee 01.07, Attachment III; Reaffirmed 10/20/12; 10/21/2017)

545.949 Electronic Transmissions

EC 8/22/2004

All reports and resolutions submitted to the MAG House of Delegates should be transmitted electronically. (Reaffirmed 10/2009; 10/2014; 10/2019)

545.952 Guests

HD 5/1/2000

Invitations of non-MAG members to the Annual House of Delegates should be left to the discretion of the Annual Session Committee, Comm: 3-00, Rec. 2 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

545.953 Reports & Resolutions

HD 10/16/2010

1) Only those reports and resolutions received at least 45 days prior to the date of the Annual Session will be included in the Handbook; 2) The reports of officers, departments and committees and all resolutions received after 45 days prior to the date of convening will be considered late reports or resolutions and distributed to each delegate at the time of registration. These will be referred to reference committees as indicated; 3) Those resolutions and reports containing recommendations received during the 10 days immediately preceding the annual session will be considered emergency business and reviewed by the Speaker. These items will be assigned to a reference committee only if their subject matter is considered of sufficient urgency as to demand inclusion on the agenda. If the item is deemed not urgent for inclusion, the item will be deferred to the Credentials Committee for their recommendation for or against consideration. Once submitted to the Credentials Committee, the resolution or report becomes an item of new business to be considered at the opening session of the House of Delegates. The House must approve it with a two-thirds majority vote for it to then be included into the agenda and assigned to a reference committee; and 4) After the opening session, any submitted item may be included on the agenda only with the unanimous approval of the House. Special Report 04.10, III (Reaffirmed 10/17/2015)

545.954 Reference Committees

HD 5/1/2000

1) Appearance before any reference committee by other than MAG members will be on approval of the Reference Committee Chairman; 2) a roster of all non-MAG members in attendance at reference committees should be kept. MAG Staff will be in charge of keeping this roster. It will be the responsibility of non-MAG members to notify MAG staff of their presence, Comm: 3-00, Rec. 3 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

545.955 CME Offer

HD 5/1/2000

MAG shall offer at least one CME program during the annual meeting of the House of Delegates, Res: 100A-00 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

545.957 Candidates for Office

HD 10/15/2016

Candidates for offices including AMA delegates and alternate delegates must, prior to the House of Delegates meeting, explicitly state their stand on current issues affecting the practice of medicine in their letter announcing their candidacy or any other campaign vehicle used in order for voting members to properly vet the candidates. (Consent Calendar Appendix III)

545.958 House of Delegates -- Length

HD 5/1/1995

All of the business of the MAG House of Delegates shall be conducted in two days. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

550
MAG: House of Delegates -Sections

550.999 L.E.A.D.S. -- MSS Program
HD 10/22/2017
MAG endorses L.E.A.D.S. (Lead, Engage, Advocate, Develop, Serve), a Medical Student Program that will: 1) increase education in organized medicine and advocacy among medical students across the state, and 2) provide opportunities to engage in organized medicine advocacy without creating additional financial burdens or distractions from student education and training...(Res. 401F.17)

555
MAG: Membership and Dues

555.973 Recruitment
HD 10/16/2011
MAG encourages medical societies to begin grassroots projects aimed at increasing involvement in organized medicine. (Special Report 04.11, Attachment III) (Reaffirmed 10/15/2016)

555.974 Dues
EC 7/25/2010
A physician may authorize MAG to automatically charge his/her credit card for dues to renew membership at the then current dues rate. This authorization must be in writing and may be revoked at any time. (Reaffirmed 10/17/2015)

555.975 Dues & Assessment / Reinstatement
HD 10/17/2009
An active member who fails to pay one year of dues may be reinstated by paying the current year's dues. If he/she fails to pay for more than one year, he/she may be reinstated with payment of the current year. (Special Report: Appendix III; Reaffirmed 10/2014; 10/2019)

555.976 Military Exemptions
HD 10/5/2008
The Medical Association of Georgia (MAG) should provide physicians serving on active deployment with gratis dues for the calendar year of their deployment. MAG will regularly convey information about service membership in MAG to the American Medical Association. (Res. 401F.08; Reaffirmed 10/20/2013; 10/20/2018)

555.977 Coordinated Membership
HD 10/5/2008
MAG encourages its county medical societies to voluntarily adopt a requirement that county medical society members also be required to be Medical Association of Georgia members. (Resolution 404F.08) (Reaffirmed 10/20/2013; 10/20/2018)

555.978 Recruitment
BD 7/28/2007

MAG asks that the student delegates to the MAG House of Delegates assume primary responsibility for recruiting student colleagues to MAG and asks that they submit an annual report on their progress in this area. (Reaffirmed 10/20/12; 10/21/2017)

555.980 Dues

HD 10/13/2007

Beginning in 2008, MAG's dues structure is revised to include first-year free memberships for newly licensed physicians excluding interns, residents and fellows and group membership discounts. (Officer 05.07; Reaffirmed 10/20/12; 10/21/2017)

555.982 Fiscal Year

HD 9/30/2006

MAG's fiscal year shall begin on January 1 of each year. (Reaffirmed 10/16/2011; 10/15/2016)

555.983 Telemarketing

HD 10/15/2005

Telemarketing shall be considered as one of the strategies for member recruitment, Resolution 302F, Resolve 2 (Reaffirmed 10/16/2010; 10/17/2015)

555.984 Membership

HD 10/16/2010

MAG shall continue to make increasing active association membership a top priority utilizing the successful strategies of recent years with particular emphasis on increased contact with young physicians and first and second year members, Special Report 04.10, III (Reaffirmed 10/17/2015)

555.985 Membership Diversity

BD 1/28/2006

The Medical Association of Georgia (MAG) recognizes the diversity of its membership with regards to religion and culture and discriminates against no members for their diversities. MAG shall direct its Annual Session Committee to become cognizant of all religious holidays when scheduling MAG's annual meetings. For all Executive Committee, Board of Directors, committees and educational meetings, MAG shall make every effort to not hold such meetings on current or future nationally recognized religious holidays. (Reaffirmed 10/16/2011; 10/15/2016)

555.988 Dues Billing Procedure

BD 2/9/2002

MAG is the only entity that may bill MAG dues and MAG will offer to bill CMS dues for those CMSs that request it. (Reaffirmed 10/2007; 10/20/12; 10/21/2017)

555.989 Direct Membership

HD 5/19/2001

MAG shall maintain a category of direct membership, allowing physicians to join MAG without the requirement of joining the county medical society. (Report of the Treasurer, Rec. 2) (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

555.990 Dues Refunds

HD 5/1/2000

MAG will grant dues refunds, when requested within 60 days after dues have been paid, and only in the

case of disablement, death or retirement, Comm: 14-00, Rec. 3 (Reaffirmed 10/2005; 10/16/2010; 10/17/2015)

555.992 Member Communication

HD 5/1/1997

MAG supports increasing visitation and communication by members of MAG leadership and staff to local, district, specialty societies, medical student and resident physician sections, similar professional societies i.e. Georgia Hospital Association, Georgia State Medical Association, Georgia Osteopathic Medical Association and other professional groups. It may be appropriate, and fruitful, to consider visibility of our Association at some hospital medical staff meetings around the state. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

555.999 Unified Membership -- AMA

HD 4/1/1985

MAG, in lieu of supporting unified membership with the AMA, shall encourage its members to join the AMA (Reaffirmed 05/2000; 10/2009; 10/2014; 10/2019)

565
MAG: Political Action

565.959 CMS Political Action

HD 10/20/2013

MAG encourages and supports local medical societies setting up local legislative committees which are composed of members who agree to become well acquainted with their state legislators; and, the local legislative committee members agree to serve as a source of information between MAG and their own state legislators during the Georgia General Assembly. (Special Committee 04.13, Attachment III; Reaffirmed 10/20/2018)

565.960 Political Activities by Physicians

HD 10/17/2009

MAG urges more participation in Georgia's political scene by physicians running for office or by active support of physicians who seek office and are supportive to the issues important to the physicians and patients of Georgia. MAG requests every specialty society in Georgia to become active in the overall objectives of MAG on its legislative programs. MAG recommends that each county medical society urge its membership to know their congressmen and senators and to actively participate in their campaigns. MAG recommends that each county society have several of their members contact their representatives and senators and to actively participate in their campaigns. MAG recommends that each county society have several of their members contact their representatives and senators regarding how specific national legislation affects the physicians of their district. (Special Report: Appendix III) (Reaffirmed 10/2014; 10/2019)

565.961 Local Legislative Committees

HD 10/4/2008

MAG urges every component medical society to establish a legislative committee, if it has not already done so, and that each component medical society's legislative community be responsible for bringing members to the state capitol to work with state policy members during the General Assembly. (Special Report 05.08, Attachment III) Reaffirmed 10/20/2013; 10/20/2018)

565.962 Unity in Medicine

HD 10/4/2008

The House of Medicine functions best when MAG, the county medical societies, and the medical specialty organizations work in concert for the betterment of healthcare for patients and physicians in the state of Georgia. MAG requests that each county medical society and medical specialty organization inform MAG of any legislative initiatives so that lines of communication and support for such initiatives will be strengthened. MAG will continue to communicate its legislative initiatives to the county medical societies and medical specialty organizations. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

565.963 Key Contacts

HD 10/4/2008

MAG and MAG Alliance will closely coordinate a legislative key contact program with the goal of having every member of the Georgia General Assembly and of Georgia's Congressional delegation closely teamed with one or more physicians and/or physicians' spouses to whom they can turn for guidance on health care issues. (Special Report 05.08, Attachment III) (Reaffirmed 10/20/2013; 10/20/2018)

565.964 National Health Care (Media Campaign)

EC 9/23/2007

MAG supports AMA policies that oppose a national health care system, and supports an AMA national media campaign consistent with MAG's position. (Reaffirmed 10/20/12; 10/21/2017)

565.966 Political Polling

HD 10/16/2010

Each component medical society and each specialty society having sufficient MAG membership to qualify for a delegate at the MAG House of Delegates should poll their membership as to what category of legislation is most important to them and relay that information to the Legislative Council prior to the Council’s deadline for such information. The Council will assist the local societies with this task. The Council on Legislation will seek input from specialty societies through the Advisory Groups to the Council on Legislation, Special Report 04.10, III (Reaffirmed 10/17/2015)

565.968 Legislation Grassroots Programs

HD 10/15/2005

MAG continues to emphasize expansion of the legislative grassroots programs of the Council on Legislation. (Comm. 01-05 Appendix III; Reaffirmed 10/20/12; 10/21/2017)

565.969 Political Contributions

HD 10/29/2004

MAG encourages physicians to look upon participation (especially financial participation) as a "part of doing business" and recommends that each physician set aside a percentage of practice income for the purpose of GAMPAC membership and for individual political contributions to such local and state candidates as may be recommended. (Reaffirmed 10/2009; 10/2014; 10/2019)

565.970 CMS Legislative Meetings

HD 5/4/2002

Each component medical society should sponsor one function for its physicians and local legislators before the convening of the session of the Georgia General Assembly for the purpose of educating

legislators on MAG priorities for the year and that the legislative team should continue assisting component medical societies in those endeavors. (Comm.: 12-02, Rec. 6; Reaffirmed 10/2007; 10/20/12; 10/21/2017)

565.972 Legislative Actions

HD 10/16/2010

The Board of Directors may reevaluate actions of the House of Delegates requiring legislative action in light of new information and the political landscape, Special Report 04.10, III (Reaffirmed 10/17/2015)

565.978 Doctor of the Day

HD 5/1/1998

MAG supports the Doctor of the Day Program (DOD) because the Medical Aid Station plays a vital role in the legislative process. (Reaffirmed 10/2005;10/16/2010; 10/17/2015)

565.980 Political Candidates' Information

EC 12/1/1997

GAMPAC shall share with the Medical Association of Georgia a list of candidates for the Office of Governor, Lt. Governor, and Secretary of State and their stance on health care issues. (Reaffirmed 9/30/2006; 10/16/2011; 10/15/2016)

565.993 Campaign Activities by Members

HD 4/1/1992

MAG urges physician and Alliance members to participate in campaign activities during election years. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)

565.995 Legislators -- Educate

HD 4/1/1992

MAG urges the physicians of Georgia to actively involve themselves in the continuing education of Georgia's legislators and other public officials on issues involved with health care policy --no citizen is better qualified to educate a public official on complex medical issues. (Reaffirmed 05/2000; 05/2002; 10/2007; 10/20/12; 10/21/2017)

565.996 Proactive Legislative Agenda

HD 4/1/1992

MAG should continue to develop and communicate a positive, proactive legislative agenda focused on the delivery of the highest reasonable quality of patient care and the protection of a physician's role in the health care system. (Reaffirmed 05/2000; 10/5/2008; 10/20/2013; 10/20/2018)