



## **MSS Reference Committee**

### **Reference Committee Members**

#### **Despina Siolas, Chair**

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Ohio State University College of Medicine and Public Health

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University of New Mexico School of Medicine

James Kearns

Columbia University College of Physicians and Surgeons

Erin Schmidt

Loma Linda University School of Medicine

David Gregg (Alternate)

University of North Carolina at Chapel Hill School of Medicine

### Items of Business

- MSS Resolution 1 - Restriction of Non-veterinary Antimicrobials in Commercial Livestock to Reduce Antibiotic Resistance
- MSS Resolution 2 - Marijuana: Medical Use and Research
- MSS Resolution 3 - Health Policy Education in Medical Schools
- MSS Resolution 4 - The Patient-Centered Medical Home Concept
- MSS Resolution 5 - Benefits of Marriage
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- MSS Resolution 7 - Survival of the J-1 Visa Waiver Program
- MSS Resolution 8 - Fundamental Melanoma Education
- MSS Resolution 9 - Support for Increase in Federal Funding for the National Institutes of Health (NIH)
- MSS Resolution 10 - Definition of MSS Standing Committees (SCs) and Transparency of the SC Application Process
- MSS Resolution 11 - A Call to Further Recognize and Expedite the Nationwide Health Information Network (NHIN)

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- GC Report C - Liability Coverage for Medical Students Completing Extramural Electives
- GC Report D - Membership Dependent Voting Apportionment
- GC Report E - National Medical Student Representation in the MSS Assembly
- GC Report F - Antimicrobial Resistance: Dearth of Novel Antibiotics









AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 2  
(A-08)

Introduced by: Sunil Aggarwal, Aaron Flanagan, and Alicia Carrasco, University of Washington School of Medicine; Sonya Khan and Liisa Bergmann, University of California, Los Angeles, School of Medicine; Trace Fender, Northeastern Ohio Universities College of Medicine; Leo Arko, University of New Mexico School of Medicine

Subject: Marijuana: Medical Use and Research

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, The federal Controlled Substances Act of 1970 categorized marijuana as a Schedule I substance  
2 not permitted for prescription use<sup>1</sup>, yet 12 states (AK, CA, CO, HI, ME, MT, NV, NM, OR, RI, VT,  
3 WA)<sup>2</sup> have laws that permit the use of marijuana when recommended by a physician; and  
4

5 Whereas, A ruling by the Ninth U.S. Circuit Court of Appeals reaffirmed and the Supreme Court let stand  
6 the right of physicians and patients to discuss the therapeutic potential of marijuana, but patients who  
7 follow their physicians' advice are put at risk for up to one year in federal prison for possession of  
8 marijuana, and up to five years in federal prison for growing one marijuana plant, as federal law does not  
9 make a distinction between medicinal and other marijuana use<sup>3</sup>; and  
10

11 Whereas, Legal access to marijuana for specific medical purposes has been supported by numerous  
12 national and state medical organizations, including the National Academy of Sciences' Institute of  
13 Medicine, American College of Physicians, American Psychiatric Association's Assembly, American  
14 Academy of Addiction Psychiatry, American Academy of Family Physicians, California Medical  
15 Association, Medical Society of the State of New York, Rhode Island Medical Society, American  
16 Academy of HIV Medicine, HIV Medicine Association, Canadian Medical Association, British Medical  
17 Association, and the Leukemia & Lymphoma Society<sup>4</sup>; and  
18

19 Whereas, The Institute of Medicine concluded after reviewing relevant scientific literature – including  
20 dozens of works documenting marijuana's therapeutic value – that “nausea, appetite loss, pain, and  
21 anxiety are all afflictions of wasting, and all can be mitigated by marijuana”<sup>5</sup>; and  
22

23 Whereas, Subsequent studies since the 1999 Institute of Medicine report, including randomized, double  
24 blind, placebo-controlled ones, continue to show the therapeutic value of marijuana in treating a wide  
25 array of debilitating medical conditions, including relieving medication side effects and thus improving  
26 the likelihood that patients will adhere to life-prolonging treatments for HIV/AIDS and Hepatitis C and  
27 alleviating HIV/AIDS neuropathy, a painful condition for which there are no FDA-approved treatments<sup>6</sup>;  
28 and  
29

30 Whereas, “Given marijuana's proven efficacy at treating certain symptoms and its relatively low toxicity,  
31 reclassification would reduce barriers to research and increase availability of cannabinoid drugs to  
32 patients who have failed to respond to other treatments”<sup>7</sup>; and

33 Whereas, “Only two cannabinoid drugs are currently licensed for sale in the U.S. (dronabinol [Marinol®]  
34 and nabilone [Cesamet®]), and both are only available in oral form” and while “useful for some, these  
35 drugs have serious limitations”<sup>8</sup>; and  
36

37 Whereas, Reclassifying marijuana as medically useful should draw from medical experience with opiates,  
38 which indicates that “opiates are highly addictive yet medically effective substances and are classified as  
39 Schedule II substances,” but “there is no evidence to suggest that medical use of opiates has increased  
40 perception that their illicit use is safe or acceptable”<sup>9</sup>; and  
41

42 Whereas, “Preclinical, clinical, and anecdotal reports suggest numerous potential medical uses for  
43 marijuana . . . unfortunately, research expansion has been hindered by a complicated federal approval  
44 process, limited availability of research-grade marijuana, and the debate over legalization”<sup>10</sup>; and  
45

46 Whereas, the National Institute on Drug Abuse (NIDA) generally supplies marijuana for the research of  
47 harms and does not automatically provide marijuana to researchers who hold an FDA Investigational New  
48 Drug (IND) and a Drug Enforcement Administration (DEA) Schedule I researcher’s registration for  
49 marijuana<sup>11</sup>; and  
50

51 Whereas, The federal government has obstructed privately funded research through NIDA’s monopoly  
52 over the production of marijuana for research, as well as through the DEA’s refusal to license any  
53 privately funded marijuana production facilities, even though DEA-licensed, private facilities produce  
54 LSD, MDMA, psilocybin, mescaline, and other Schedule I drugs; and  
55

56 Whereas, Despite these obstructions, the accumulated scientific data regarding marijuana’s safety and  
57 efficacy in certain clinical conditions and its increasingly accepted medical use in treatment can no longer  
58 be ignored<sup>12</sup>; therefore be it  
59

60 RESOLVED, That our AMA support review of marijuana’s status as a Schedule I controlled substance,  
61 its reclassification into a more appropriate schedule, and revision of the current protocol for obtaining  
62 research-grade marijuana so that it conforms to the same standards established for obtaining every other  
63 scheduled drug for legitimate research purposes; and be it further  
64

65 RESOLVED, That our AMA strongly support exemption from federal criminal prosecution, civil  
66 liability, and professional sanctioning for physicians who recommend medical marijuana in accordance  
67 with state law, as well as full legal protections for patients who use medical marijuana under these  
68 circumstances; and be it further  
69

70 RESOLVED, That this resolution be promptly forwarded to the House of Delegates at A-08 for national  
71 action.

Fiscal note: TBD

Date received: 4/10/08

References:

1. Drug Enforcement Administration (DEA) drug scheduling. Available at <http://www.dea.gov/pubs/scheduling.html>.
2. USA Today. “Medical marijuana laws vary among states.” (2007) Available at [http://www.usatoday.com/money/workplace/2007-04-16-marijuana-chart\\_N.htm](http://www.usatoday.com/money/workplace/2007-04-16-marijuana-chart_N.htm).
3. DEA federal penalties for marijuana. Available at <http://www.dea.gov/agency/penalties.htm>.
4. Endorsements document. Available at <http://www.mediafire.com/?0oijtfxwgdi>.
5. Joy, J., Watson, S., and Benson, J. Marijuana and Medicine: Assessing the Science Base. National Academy Press, 1999.

6. deJong B.C., et al, "Marijuana Use and its Association With Adherence to Antiretroviral Therapy Among HIV-Infected Persons With Moderate to Severe Nausea," *Journal of Acquired Immune Deficiency Syndromes*, January 1, 2005; Sylvestre D.L., Clements B.J., and Malibu Y., "Cannabis Use Improves Retention and Virological Outcomes in Patients Treated for Hepatitis C," *European Journal of Gastroenterology and Hepatology*, September 2006; Abrams D., et al, "Cannabis in Painful HIV-Associated Sensory Neuropathy," *Neurology*, February 13, 2007.
7. American College of Physicians, "Supporting Research into the Therapeutic Role of Marijuana," January 2008: 10. Available at [http://www.acponline.org/advocacy/where\\_we\\_stand/other\\_issues/medmarijuana.pdf](http://www.acponline.org/advocacy/where_we_stand/other_issues/medmarijuana.pdf).
8. *Ibid*, p 8.
9. *Ibid*, p 10.
10. *Ibid*, p 3.
11. National Institutes of Health. (1999) Announcement of the Department of Health and Human Services' Guidance on Procedures for the Provision of Marijuana for Medical Research. Available at <http://grants.nih.gov/grants/guide/notice-files/not99-091.html>.
12. E Lawrence O. Gostin, JD, LLD (Hon), Georgetown Law Professor, "Medical Marijuana, American Federalism, and the Supreme Court." *JAMA*. 2005;294:842-844.

Relevant AMA and MSS Policy:

#### **H-95.952 Medical Marijuana**

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA recommends that marijuana be retained in Schedule I of the Controlled Substances Act pending the outcome of such studies. (3) Our AMA urges the National Institutes of Health (NIH) to implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research into the medical utility of marijuana. This effort should include: a) disseminating specific information for researchers on the development of safeguards for marijuana clinical research protocols and the development of a model informed consent on marijuana for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of marijuana for clinical research purposes; c) confirming that marijuana of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the Drug Enforcement Agency who are conducting bona fide clinical research studies that receive Food and Drug Administration approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that the NIH should use its resources and influence to support the development of a smoke-free inhaled delivery system for marijuana or delta-9-tetrahydrocannabinol (THC) to reduce the health hazards associated with the combustion and inhalation of marijuana. (5) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. (CSA Rep. 10, I-97; Modified: CSA Rep. 6, A-01)

#### **100.006 MSS Reclassification of Heroin for Therapeutic Use**

AMA-MSS will ask the AMA to: (1) strongly support research into the therapeutic use of heroin as a Schedule I drug in the context of addiction treatment, for those patients for whom other standard methods have been tried and have failed; and (2) urge the Drug Enforcement Administration, Department of Health and Human Services, and National Institute of Drug Abuse to allow such research with appropriate oversight and safeguards. (MSS Sub Res 20, A-98) (AMA Res 504, I-98, Not Adopted) (Reaffirmed: MSS Rep E, I-03)

#### **H-95.995 Health Aspects of Marijuana**

Our AMA: 1. discourages marijuana use, especially by persons vulnerable to the drug's effects and in high-risk situations; 2. supports the determination of the consequences of long-term marijuana use through concentrated research; and 3. supports the modification of state law to reduce the severity of penalties for possession of marijuana. (CSA Rep. D, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

#### **H-95.997 Marijuana**

Our AMA:

1. recommends personal possession of insignificant amounts of that substance be considered a misdemeanor with commensurate penalties applied; 2. believes a plea of marijuana intoxication not be a defense in any criminal proceedings; and 3. urges that educational efforts be expanded to all segments of the population. (BOT Rep. J, A-72; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00)

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 3  
(A-08)

Introduced by: Erica Dommasch, Thomas McCann, and Christopher Tarassoff, UMDNJ-Robert Wood Johnson Medical School

Subject: Health Policy Education in Medical Schools

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, Physicians should have a significant role in health policy, as physicians' expertise is essential  
2 for properly addressing major quality, access, public health, and policy concerns<sup>1</sup>; and  
3

4 Whereas, Despite the escalating complexity of legal, ethical, and financial issues pertaining to health care,  
5 physician participation in such legislative measures has been limited; specifically, only 25 out of 2196  
6 (1.1%) members of Congress were physicians from the years 1960 to 2004, a period that parallels the  
7 enactment of Medicare and Medicaid legislation and thus represents an era in which the federal  
8 government has been actively involved in shaping health care policy<sup>2</sup>; and  
9

10 Whereas, The Institute on Medicine as a Profession's (IMAP) Survey on Medical Professionalism  
11 concluded that 90% of respondents rated community service, political involvement, and collective  
12 advocacy to be important, demonstrating that many physicians recognize professional responsibilities  
13 outside direct clinical practice<sup>3</sup>; and  
14

15 Whereas, Today's medical students are inheriting a health care system in crisis; although national medical  
16 bodies, including the Council of Medical Specialty Societies, have stated that physicians have an ethical  
17 obligation to participate in the formation of health care policy<sup>4</sup>, it is unclear how well physicians are  
18 prepared by their medical education to do this; and  
19

20 Whereas, The "Common Program Requirements: General Competencies" from 2007 published by the  
21 Accreditation Committee on Graduate Medical Education (ACGME) requires that residents demonstrate  
22 an awareness of and responsiveness to the larger context and system of health care and advocate for  
23 quality patient care and optimal patient care systems<sup>5</sup>; and  
24

25 Whereas, Surveys of current medical students indicate that while students have some understanding of the  
26 healthcare system, many have misconceptions of the magnitude of healthcare problems and insufficient  
27 understanding of the complexities of the U.S. healthcare system<sup>6</sup>; and  
28

29 Whereas, A cross-sectional study evaluating medical student knowledge of health policy issues found no  
30 difference between first and fourth year medical students, thus raising concerns about the content and  
31 effectiveness of the existing curricula in health policy; while 96% of respondents felt that knowledge of  
32 health policy is important to their career, 54% expressed dissatisfaction with the health policy curriculum  
33 in medical school<sup>6</sup>; and  
34

35 Whereas, The current medical curriculum at nearly all medical schools contains very little formal  
36 education in health policy<sup>7</sup>; and

1 Whereas, Health policy courses already implemented in select U.S. medical schools have demonstrated  
2 that students become more involved in reading health policy legislation, have a better understanding of  
3 the legislative process and its ramifications for health care, and are more interested in health policy-  
4 related issues<sup>8</sup>; therefore be it

5  
6 RESOLVED, That our AMA strongly encourage medical schools to include within their core curricula  
7 health policy education examining the political, economic, and social policies influencing health care, as  
8 well as medical decision making; and be it further

9  
10 RESOLVED, That our AMA work with the Association of American Medical Colleges (AAMC) to  
11 integrate health policy education into the core medical school curricula and establish basic topics  
12 regarding health policy education that should be included within medical education; and be it further

13  
14 RESOLVED, That this resolution be forwarded to the AMA House of Delegates.

Fiscal note: TBD

Date received: 4/18/08

References:

1. Gruen RL, Pearson SD, Brennan TA, Physician-citizens—public roles and professional obligations. *JAMA*. 2004; 291:94-98.
2. Kraus, C.K. and T.A. Suarez, Is There a Doctor in the House? . . . Or the Senate?: Physicians in US Congress. 1960-2004. *JAMA*, 2004. 292(17): p. 2125-2129.
3. Gruen, R.L., E.G. Campbell, and D. Blumenthal, Public Roles of US Physicians: Community Participation, Political Involvement, and Collective Advocacy. *JAMA*, 2006. 296(20): p. 2467-2475.
4. Council of Medical Specialty Societies. "Ethics Statement." (1999) Available at <http://www.cmss.org/print.cfm?itemid=1100>.
5. Accreditation Committee on Graduate Medical Education (ACGME), "Common Program Requirements: General Competencies." (2007) Available at <http://www.acgme.org/outcome/comp/compCPRL.asp>.
6. Agrawal, J., Medical Students' Knowledge of the US Health Care System and Their Preferences for Curricular Change: A National Survey. *Academic Medicine*, 2005. 80(5): p. 484-488.
7. Gupta, R., Why Should Medical Students Care about Health Policy? *PLoS Medicine*, 2006. 3(10): p. e199.
8. Quraishi, S., The Health Policy and Legislative Awareness Initiative at the Pennsylvania State University College of Medicine: theory meets practice. *Academic Medicine*, 2005. 80(5): p. 443-447.

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 4  
(A-08)

Introduced by: Jacob Bryan, Ohio State University College of Medicine; Emily Lange, University of Missouri School of Medicine

Subject: The Patient-Centered Medical Home Concept

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, The medical home is a health care setting that facilitates partnerships between individual  
2 patients, their personal physicians, and when appropriate, the patient’s family; and  
3

4 Whereas, The patient-centered medical home (PCMH or medical home) is defined by the American  
5 Academy of Family Physicians, the American Academy of Pediatrics, the American College of  
6 Physicians, and the American Osteopathic Association in the “Joint Principles of the Patient-Centered  
7 Medical Home”<sup>1</sup>; and  
8

9 Whereas, The “Joint Principles of the Patient-Centered Medical Home,” defines the PCMH as a model of  
10 health care delivery that incorporates the following principles: (1) Personal physician, (2) Physician  
11 directed medical practice, (3) Whole person orientation, (4) Care is coordinated and/or integrated, (5)  
12 Quality and safety, (6) Enhanced access, and (7) Payment<sup>1</sup>; and  
13

14 Whereas, Access to a medical home is significantly affected by race/ethnicity and poverty<sup>2</sup>; and  
15

16 Whereas, When adults have health insurance coverage and a medical home, racial and ethnic disparities  
17 in access and quality of care are reduced or even eliminated<sup>2</sup>; and  
18

19 Whereas, Parents of children who do have a medical home report significantly less delayed or forgone  
20 care, significantly fewer unmet health care needs, significantly fewer unmet needs for family support  
21 services, and increased patient satisfaction<sup>3</sup>; and  
22

23 Whereas, Increasing the ratio of primary care physicians to overall population is associated with better  
24 health outcomes, often at lower costs<sup>4</sup>; and  
25

26 Whereas, Our AMA is committed to improving the quality of our nation’s primary care infrastructure and  
27 improving the overall health of the general population; therefore be it  
28

29 RESOLVED, That our AMA adopt the definition of the patient-centered medical home that is put forth  
30 by the American Academy of Family Physicians, the American Academy of Pediatrics, the American  
31 College of Physicians, and the American Osteopathic Association in the “Joint Principles of the Patient-  
32 Centered Medical Home;” and be it further  
33

34 RESOLVED, That our AMA advocate that every American should be provided with primary care  
35 services within the setting of a patient-centered medical home; and be it further

- 1 RESOLVED, That our AMA support increased reimbursement for medical practice centers that utilize the  
 2 patient-centered medical home concept as their model of care; and be it further  
 3  
 4 RESOLVED, That our AMA work with organizations which includes but is not limited to the American  
 5 Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and  
 6 the American Osteopathic Association to promote legislation that will provide every American with a  
 7 patient-centered medical home; and be it further  
 8  
 9 RESOLVED, That our AMA Health Policy Group establish the patient-centered medical home concept as  
 10 an important aspect of health care reform to be addressed within “Expanding Health Insurance: The AMA  
 11 Proposal for Reform;” and be it further  
 12  
 13 RESOLVED, That this resolution be forwarded to the AMA House of Delegates at I-08.

Fiscal note: TBD

Date received: 4/21/08

References:

1. American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, American Osteopathic Association. “Joint principles of the patient-centered medical home.” (2007) Accessed at: [www.medicalhomeinfo.org/Joint%20Statement.pdf](http://www.medicalhomeinfo.org/Joint%20Statement.pdf) on 12 March 2008.
2. A. Beal, M. Doty, S. Hernandez, K. Shea, and K. Davis. “Closing the Divide: How Medical Homes Promote Equity In Health Care.” (2007) *The Commonwealth Fund*, pub. no. 1035. Accessed at: [www.commonwealthfund.org](http://www.commonwealthfund.org) on 12 March 2008.
3. B. Strickland, M. McPherson, G. Weissman, P. van Dyck, ZJ Huang, and P Newacheck. Access to the medical home: results of the National Survey of Children with Special Health Care Needs. *PEDIATRICS* Vol. 113 No. 5 May 2004, pp. 1485-1492.
4. B. Starfield, L. Shi, A. Grover, and J. Macinko. The Effects of Specialist Supply on Population’s Health: Assessing the Evidence. (2005) *Specialists and Health*, W5-97.

Relevant AMA and MSS Policy:

**H-290.972 Health Savings Accounts in the Medicaid Program**

1. Our AMA encourages state medical associations to assist in the design, monitoring, and evaluation of state Health Opportunity Account (HOA) demonstrations.
2. It is the policy of our AMA that states offering Medicaid beneficiaries HOAs or similar coverage modeled after Health Savings Accounts (HSAs) should adhere to the following principles: (a) Make beneficiary participation voluntary; (b) Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible; (c) Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health; (d) Set deductibles at 100% of account contributions, but no higher; (e) Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits; (f) Allow the deductible limits for families to be the lower of either the individual or family combined deductible; (g) Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits; (h) Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages; (i) Encourage HOA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care; (j) Prohibit use of HOA funds for non-medical purposes, but consider allowing HOA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage; (k) Monitor the impact on utilization and beneficiary financial burden; (l) Test broadening of eligibility to include currently ineligible beneficiary groups; and (m) Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian. (CMS Rep. 1, I-06)

**H-165.920 Individual Health Insurance**

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

**D-200.986 Impact of Increasing Specialization and Declining Generalism in the Medical Profession**

Our AMA will:

- (1) Develop policy regarding the development and maintenance of the appropriate workforce balance between generalists and specialists in its Initiative to Transform Medical Education and in future studies or deliberations related to the medical workforce.
- (2) Through its Council on Medical Education, continue its close collaborations with the Association of American Medical Colleges, American Board of Medical Specialties, and Accreditation Council for Graduate Medical Education by actively participating in processes which define the content and scope of education and practice, including participation in defining medical school curriculum through the Liaison Committee on Medical Education and reviewing and commenting on proposed changes in the accreditation requirements of Graduate Medical Education programs by the ACGME.
- (3) Continue to seek input from the Federation on the need for physicians by both geographic region and specialty.
- (4) Support the concept of partnerships between primary care physicians and patients to coordinate access to all needed medical services and consultations (a "medical home") for all patients.
- (5) Encourage physician reimbursement changes which would make generalist physician practice more attractive.
- (6) Work with the Federation to convene and staff a "medical workforce commission" (which would include representatives of the medical education community, major specialty societies and the public) to project the optimal medical workforce for the US and to develop strategies to achieve that. (CME Rep. 12, A-06; Reaffirmation I-06)

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 5  
(A-08)

Introduced by: Jeremy Toler, West Virginia University School of Medicine

Subject: Benefits of Marriage

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, Societies have highly valued marriage for the many benefits it brings to the societies themselves  
2 as well as the mutual benefit of the couples involved and the dependent children within those unions; and  
3

4 Whereas, In the United States, only Massachusetts permits marriage with all of its documented benefits to  
5 both heterosexual and non-heterosexual couples and their dependent children, and the other 49 states deny  
6 the benefits of marriage to non-heterosexual couples and their dependent children; and  
7

8 Whereas, Peer-reviewed research strongly suggests that sexual orientation is natural, biological, morally  
9 neutral and immutable, is not contagious or learned, has no relation to a person's ability to form deep and  
10 lasting relationships, to parent, or contribute to society; and  
11

12 Whereas, Our AMA strongly opposes discrimination based on sexual orientation or gender identity (H-  
13 65.983); and  
14

15 Whereas, Our AMA supports appropriate legislation that will provide health coverage for the greatest  
16 number of children, adolescents, and pregnant women (H-165.877); and  
17

18 Whereas, The 2000 U.S. Census reported that 33% of lesbian households and 22% of gay households had  
19 dependent children living with them who were denied the benefits and protections that marriage brings to  
20 heterosexual married households and the dependent children of those households<sup>1</sup>; and  
21

22 Whereas, The American Psychiatric Association, American Psychological Association, American  
23 Psychoanalytic Association, and the American Academy of Pediatrics all confirm the peer-reviewed  
24 research evidence that children raised in same sex households develop equally well in all aspects and are  
25 as psychologically healthy as those raised in heterosexual families but are still denied the legal and  
26 financial family protections offered to children of married heterosexual parents<sup>2,8</sup>; and  
27

28 Whereas, The American Psychiatric Association, American Psychological Association, American  
29 Psychoanalytic Association, the American Academy of Pediatrics, and several other professional  
30 organizations confirm that civil marriage (with or without clergy) confers essential mental and physical  
31 health benefits and longevity for couples and greater legal and financial security for children, parents, and  
32 seniors, and have endorsed civil marriage for the health of same sex couples and their families<sup>2,8</sup>; and  
33

34 Whereas, Our AMA supports equality in laws affecting health care of individuals in same sex partner  
35 households and their dependent children with the goal of reducing health disparities of these families (D-  
36 65.995); therefore be it

- 1 RESOLVED, That our American Medical Association evaluate existing data concerning same-sex  
 2 couples and their dependent children and report back to the House of Delegates to determine whether  
 3 there is sufficient evidence of health care disparities for these couples and children because of their  
 4 exclusion from civil marriage.

Fiscal note: TBD

Date received: 4/24/08

References:

1. Simmons T and O'Connell M. "Married-Couple and Unmarried-Partner Households: 2000." *Census 2000 Special Reports*. U.S. Census Bureau and U.S. Department of Commerce. 2003.
2. American Academy of Pediatrics. "AAP Response to the Proposed 'Marriage Amendment' to the Constitution of the United States of America." 2004.
3. Gold, MA, et al. "Children of Gay or Lesbian Parents." *Pediatrics in Review*. 1994, 15(9): 354-8.
4. Meezan W and Rauch J. "Gay Marriage, Same-Sex Parenting, and America's Children." *The Future of Children*. 2005. 15(2), pp 97-115.
5. Pawelski JG, et al. "The Effects of Marriage, Civil Union, and Domestic Partnership Laws on the Health and Well-being of Children." *Pediatrics*. 2006, 118(1), pp 349-364.
6. Tasker F. "Lesbian Mothers, Gay Fathers, and Their Children: A Review." *Developmental and Behavioral Pediatrics*. 2005, 26(3), pp 224-240.
7. King M, and Bartlett A. "What Same Sex Civil Partnerships May Mean for Health." *Journal of Epidemiology and Community Health*. 2006, 60, pp 188-191.
8. The American Psychiatric Association. "Support of Legal Recognition of Same-Sex Civil Marriage: Position Statement." 2005.

Relevant AMA and MSS Policy:

**H-65.983 Nondiscrimination Policy.**

The AMA affirms that it has not been its policy now or in the past to discriminate with regard to sexual orientation or gender identity. (Res. 1, A-93; Reaffirmed: CCB Rep. 6, A-03; Modified: BOT Rep. 11, A-07)

**H-165.877 Increasing Coverage for Children**

Our AMA:

- (1) supports appropriate legislation that will provide health coverage for the greatest number of children, adolescents, and pregnant women;
- (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
- (3) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children in accordance with AMA Policy 165.920[2] the AMA recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs;
- (4) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18;
- (5) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23;
- (6) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families;
- (7) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package;
- (8) advocates that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits that meet the standards of the AMA standard benefit package;

- (9) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage;
- (10) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage;
- (11) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group;
- (12) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; and
- (13) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated three million children currently eligible for but not covered under this program. (Sub. Res. 208, A-97; CMS Rep. 7, A-97; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Reaffirmation A-02; Reaffirmation A-05; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07)

#### **D-65.995 Health Disparities Among Gay, Lesbian, Bisexual and Transgender Families**

Our AMA will work to reduce the health disparities suffered because of unequal treatment of minor children and same sex parents in same sex households by supporting equality in laws affecting health care of members in same sex partner households and their dependent children. (Res. 445, A-05)

#### **H-65.990 Civil Rights Restoration**

The AMA reaffirms its long-standing policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual's sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age. (BOT Rep. LL, I-86; Amended by Sunset Report, I-96; Modified: Res. 410, A-03)

#### **H-65.992 Continued Support of Human Rights and Freedom**

Our AMA continues (1) to support the dignity of the individual, human rights and the sanctity of human life, and (2) to oppose any discrimination based on an individual's sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies. (Sub. Res. 107, A-85; Modified by CLRPD Rep. 2, I-95; Reaffirmation A-00; Reaffirmation A-05; Modified: BOT Rep. 11, A-07)

#### **B-1.50 Discrimination**

Membership in any category of the AMA or in any of its constituent associations shall not be denied or abridged because of sex, color, creed, race, religion, disability, ethnic origin, national origin, sexual orientation, gender identity, age, or for any other reason unrelated to character, competence, ethics, professional status or professional activities.

#### **G-630.130 Discrimination**

It is the policy of our AMA not to hold meetings or pay member, officer or employee dues in any club, restaurant, or other institution that has exclusionary policies based on gender, race, color, religion, national origin, gender identity, or sexual orientation. (Res. 101, I-90; Reaffirmed: Sunset Report, I-00; Consolidated: CLRPD Rep. 3, I-01; Modified: BOT Rep. 11, A-07)

#### **H-215.965 Hospital Visitation Privileges for GLBT Patients**

Our AMA encourages all hospitals to add to their rules and regulations, and to their Patient's Bill of Rights, language permitting same sex couples and their dependent children the same hospital visitation privileges offered to married couples. (Res. 733, A-06)

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 6  
(A-08)

Introduced by: Chris Bucciarelli and Devin Bustin, University of Florida College of Medicine  
Subject: Increased Funding for AMA-MSS Regional Meetings  
Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, The AMA-MSS regards Regional meetings of the AMA-MSS as an important component of  
2 our Section's yearly activities; and  
3

4 Whereas, The Regional meetings offer an opportunity for the participants to develop leadership skills, as  
5 well as personal and professional relationships; and  
6

7 Whereas, Those new to our organization use the meeting as a venue to learn about the programmatic and  
8 legislative priorities of the AMA and AMA-MSS, especially for those students that do not have the  
9 opportunity to attend a National meeting; and  
10

11 Whereas, Participants gain experience and insight into the development of legislation to be presented to  
12 the House of Delegates; and  
13

14 Whereas, Time spent during the Regional meeting is used to develop an agenda which to present to the  
15 House of Delegates at the National Meetings; and  
16

17 Whereas, Regional meetings are a place in which the vital role of increasing AMA membership and  
18 maintaining involvement through students' professional careers can be emphasized; and  
19

20 Whereas, The AMA currently contributes \$1,000 per region annually towards the meeting that brings  
21 together several states' medical schools; and  
22

23 Whereas, The AMA-MSS is of the opinion that the costs of producing a quality Regional meeting far  
24 exceeds the \$1,000 currently allocated; and  
25

26 Whereas, An increase in budget would allow for an improved result for each meeting; therefore be it  
27

28 RESOLVED, That the AMA-MSS request the House of Delegates of the AMA to support a resolution  
29 that would increase funding for the seven AMA-MSS Regional meetings beyond the present amount of  
30 \$1,000 annually.

Fiscal note: TDB

Received: 4/25/08

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 7  
(A-08)

Introduced by: Justin Taylor, University of New Mexico School of Medicine

Subject: Survival of the J-1 Visa Waiver Program

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, Having an adequate number of physicians is essential to providing quality health care in rural  
2 areas, and rural areas often experience difficulties in the recruitment and retention of physicians<sup>1</sup>; and  
3

4 Whereas, The J-1 visa program for International Medical Graduates allows students to remain in the  
5 United States after residency training through state sponsored visa waiver programs called the Conrad 30  
6 programs by waiving the requirement for returning to their home countries for two years before applying  
7 for a permanent visa and allows a physician to stay in the country to practice in a federally designated  
8 Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA)<sup>2,3</sup>; and  
9

10 Whereas, Studies have shown that International Medical Graduates comprise a large proportion of  
11 physicians in rural shortage areas, and many rural counties would be without a physician if not for the  
12 service of International Medical Graduates<sup>4</sup>, but the number of International Medical Graduates entering  
13 the United States for residencies on a J-1 visa is declining; thus, fewer Foreign Medical Graduates are  
14 seeking waivers to stay after completing their training<sup>5</sup>; and  
15

16 Whereas, An H1B visa is a temporary worker's visa allowing those in specialty occupations, such as  
17 medicine, to work in the United States for three years and to apply for a Green Card immediately after  
18 finishing residency<sup>6</sup>, and International Medical Graduates are getting advice to pursue H1B visas over J-1  
19 visas as H1B visas are viewed as being less restrictive<sup>7,8</sup>; and  
20

21 Whereas, Current studies into the impacts of these recent trends in how International Medical Graduates  
22 enter practice in the U.S. will soon be published<sup>9,10</sup>, and the AMA should be prepared to address these  
23 important issues; and  
24

25 Whereas, The AMA supports efforts to improve rural health via the J-1 visa waiver program and the  
26 Conrad 30 state programs (H-465.994, D-200.989, D-255.993); therefore be it  
27

28 **RESOLVED**, That our AMA-MSS GC form an ad hoc committee to study whether the changes in the  
29 decisions of foreign medical graduates to practice in rural underserved areas based on visa requirements  
30 justify immediate forwarding to the AMA House of Delegates for study of the problems presented by the  
31 current decline in J1 visa waiver program and the alternative H1B visa.

Fiscal note: TBD

Received: 4/25/08

## References:

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3. Rural J-1 Visa Waiver Resources. Information guide from the Rural Assistance Center Online at  
[www.raconline.org/info\\_guides/hc\\_providers/j1visa.php](http://www.raconline.org/info_guides/hc_providers/j1visa.php)
4. Mueller, Keith J. Immediate and future role of the J-1 Visa waiver program for physicians: the consequences of change for rural health care service delivery. Report from the Rural Policy Research Institute special J-1 visa waiver program task force. (2002) Available at  
[www.unmc.edu/ruprihealth/Pubs/P2002-3](http://www.unmc.edu/ruprihealth/Pubs/P2002-3)
5. International Medical Graduate Physicians in the U.S.: Changes Since 1981. In National Health Workforce Assessment of the Past and Agenda for the Future: Proceedings of and International Symposium. (2006) Working paper available at [www.ruralhealthresearch.org/projects/100002095](http://www.ruralhealthresearch.org/projects/100002095)
6. H-1B Frequently Asked Questions. Available at [www.uscis.gov](http://www.uscis.gov) search H-1B visa
7. Croasdale, Myrle. Jinx of the J-1 visa IMGs finding other paths to residency. AMNews (March 10, 2008)
8. The H1-B visa: FMGs and Physician. The Doctor Job website online at  
[www.thedoctorjob.com/careercorner/view\\_article.php?id\\_article=28](http://www.thedoctorjob.com/careercorner/view_article.php?id_article=28)
9. National Study of Available Information on H1-B, J-1 and other International Medical Graduate Information  
Research center: WWAMI Rural Health Research Center  
Funder: Office of Rural Health Policy (ORHP) Anticipated completion date: April 2008
10. Contribution of J-1 Visa International Medical Graduates to the Rural Physician Workforce  
Research center: WWAMI Rural Health Research Center Funder: Office of Rural Health Policy (ORHP)  
Anticipated completion date: April 2008
11. AMA policy H-465.994 Committee on Rural Health
12. AMA policy D-200.989 Incentive Programs to Improve Access to Health Care Services in Underserved Areas
13. AMA policy D-255.993 J-1 Visas and Waivers

## Relevant AMA and MSS policy:

**H-465.994 Committee on Rural Health**

The AMA (1) supports continued and intensified efforts to develop and implement proposals for improving rural health care, (2) urges physicians practicing in rural areas to be actively involved in these efforts, and (3) advocates widely publicizing AMA's policies and proposals for improving rural health care to the profession, other concerned groups, and the public. (Sub. Res. 72, I-88; Reaffirmed: Sunset Report, I-98)

**D-200.989 Incentive Programs to Improve Access to Health Care Services in Underserved Areas**

Our AMA will (1) conduct an analysis of the creative use of tax credits, student loan deferment and loan forgiveness programs, J-1 visa waivers, and practice subsidies as financial incentives to physicians for providing care in identified underserved areas; and (2) work with state medical societies and other appropriate entities to identify, catalogue, and evaluate the effectiveness of incentive programs, including the J-1 visa waiver program, designed to promote the location and retention of physicians in rural and urban underserved areas and, consequently, improve patient access to health care in these areas. (Res. 810, I-05; Reaffirmation I-06)

**D-255.993 J-1 Visas and Waivers**

(1) The AMA shall encourage HHS and other interested government agencies to continue sponsorship of the J-1 visa waiver program. (2) If the USDA does not continue in its role as an interested government agency (IGA), the AMA encourage HHS to expand its J-1 visa waiver program. (3) The AMA will work with federal agencies to ensure better coordination of federal, state, and local agencies in monitoring the placement and enforcement of physicians' service requirements through the J-1 waiver and Conrad-30 programs with a report back at A-03. (BOT Rep. 11, I-02)

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 8  
(A-08)

Introduced by: David J. Rayhan, University of California, Irvine, School of Medicine; Brittney Culp,  
Texas Tech University Health Sciences Center School of Medicine

Subject: Fundamental Melanoma Education

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, Malignant melanoma is a leading cause of preventable cancer deaths, especially in youth, in the  
2 United States of America<sup>1</sup>; and

3  
4 Whereas, There has been a consistent increase in the incidence of melanoma in American youth<sup>1</sup>; and

5  
6 Whereas, Melanoma is unique among pediatric cancers in that is it preventable, easily detectable and  
7 easily treated at an early stage<sup>2</sup>; and

8  
9 Whereas, The AMA currently recommends that physicians screen themselves and their families for  
10 melanoma (H-55.980); and

11  
12 Whereas, The AMA also supports the creation of Melanoma programs to educate grade and high school  
13 students about melanoma screening and prevention; and

14  
15 Whereas, The aforementioned activities require that a physician have knowledge regarding melanoma  
16 screening and prevention; and

17  
18 Whereas, The AMA already supports training policies for medical students regarding specific diseases  
19 (H-295.980, H-295.988); therefore be it

20  
21 **RESOLVED**, That our AMA recommend that U.S. accredited medical schools provide education about  
22 the fundamentals of melanoma screening and prevention to medical students during their first two years  
23 (or equivalent basic science years) of medical education.

24  
Fiscal note: TBD

Date received: 4/25/08

## References:

1. Linabery AM, Ross JA. Trends in childhood cancer incidence in the U.S. (1992-2004). *Cancer*. 2008 Jan 15;112(2):416-32.
2. Lewis KG. Trends in pediatric melanoma mortality in the United States, 1968 through 2004. *Dermatol Surg*. 2008 Feb;34(2):152-9. Epub 2007 Dec 17.

## Relevant AMA and MSS Policy:

**H-55.980 Skin Cancer Self-Examination**

The AMA (1) encourages all physicians to perform skin self-examinations and to examine themselves and their families on the first Monday of the month of May, which is designated by the American Academy of Dermatology as Melanoma Monday; (2) encourages physicians to examine their patients' skins for the early detection of melanoma and nonmelanoma skin cancer; (3) urges physicians to encourage their patients to perform regular self-examinations of their skin and assist their family members in examining areas that may be difficult to examine; and (4) encourages physicians to educate their patients concerning the correct way to perform skin self-examination. (Sub. Res. 505, A-96; Reaffirmation I-98)

**H-295.980 Clinical Training in STD for Medical Students/Physicians in Training**

The AMA urges medical schools to provide supervised training in sexually transmitted diseases for all medical students and physicians in training. (Sub. Res. 88, A-85; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed: CME Rep. 2, A-05)

**H-295.988 Alcohol and Substance Abuse Education of Medical Students and Residents**

In cooperation with other organizations, the AMA supports the education of medical students and residents in the prevention and treatment of alcoholism and substance abuse in our nation's youth. (Sub. Res. 100, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: CME Rep. 2, A-04; Reaffirmed: CME

**60.011MSS Sun Protection Programs in Elementary Schools**

AMA-MSS will ask the AMA to work with the National Association of State Boards of Education, the Centers for Disease Control and Prevention, and other appropriate entities to encourage elementary schools to develop sun protection policies. (MSS Res 16, A-04) (Reaffirmed: MSS Res 16, I-05)







AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 10  
(A-08)

Introduced by: Felicity Kelly and Chirag B. Patel; University of Texas – Houston Medical School; Cassandra Bradby, Meharry Medical College; Kamel Brakta, Louisiana State University School of Medicine - Shreveport; Patricia Nwajuaku, University of California, Los Angeles, Charles Drew University of Medicine and Science; Kawan Swain, East Carolina University Brody School of Medicine

Subject: Definition of MSS Standing Committees (SCs) and Transparency of the SC Application Process

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, The AMA-MSS Governing Council (GC) is elected by the MSS Assembly, and GC roles are  
2 explicitly defined in our AMA-MSS Internal Operating Procedures (IOPs)<sup>1</sup>; and  
3  
4 Whereas, Applications for GC positions are made available online prior to the meeting at which the  
5 AMA-MSS Assembly members elect the candidates to fill the GC positions; and  
6  
7 Whereas, AMA-MSS Convention Committees are selected by the GC and their specific roles are  
8 explicitly defined in our AMA-MSS IOPs despite only being constituted for the three-day duration of an  
9 AMA-MSS Interim or Annual meeting; and  
10  
11 Whereas, Each member of at least the past five GCs has previously served on an AMA-MSS Standing  
12 Committee (SC), on a Convention Committee, as a Liaison, as a student Councilor, and/or as a Region  
13 officer prior to his/her term on the GC<sup>2</sup> (with the last four leadership opportunities, but not the first, being  
14 defined in the MSS IOPs<sup>1</sup>); and  
15  
16 Whereas, The AMA-MSS SCs are a necessary and integral part of the infrastructure<sup>3</sup> of our AMA-MSS  
17 and are responsible for researching and writing the vast majority of reports presented at national AMA-  
18 MSS meetings; and  
19  
20 Whereas, Membership on most of the AMA-MSS SCs lasts for one calendar year, the same duration of  
21 time for all GC positions except Chair-Elect, Immediate Past Chair, and BOT-Elect (which each last for  
22 six months); and  
23  
24 Whereas, (1) Applications for AMA-MSS Councilor positions require a dean’s letter prior to submission  
25 to the AMA and (2) Applications for GC positions require prior approval by a “dean or clinical  
26 preceptor”<sup>4</sup> prior to submission to the AMA; and  
27  
28 Whereas, The AMA-MSS SC applications are submitted without being vouched for by the chapter  
29 President, Dean of Student Affairs or clinical preceptor; and which are not made available to the MSS;  
30 and

1 Whereas, The definition of and the process of selection to AMA-MSS SCs is not delineated in the current  
2 AMA-MSS IOPs<sup>1</sup> even though SCs are referred to throughout the AMA-MSS Digest of Policy Actions<sup>5</sup>;  
3 therefore be it

4  
5 RESOLVED, That the definition of AMA-MSS SCs be explicitly written into our AMA-MSS IOPs as  
6 follows:

7  
8 A new article (Article VII) titled “MSS Standing Committees” to be inserted after the current  
9 Article VI and which states:

10 “The Standing Committees shall be appointed by the Governing Council. These committees are  
11 to support the MSS in researching resolutions, writing relevant reports, providing programming  
12 for national AMA-MSS meetings, and to generally support the mission of the AMA-MSS.”  
13

14 and be it further

15  
16 RESOLVED, That the application for Standing Committees be updated to request the chapter President or  
17 a Dean of Student Affairs or clinical preceptor to review and sign the application (instructions: “I have  
18 reviewed this application and it is accurate to the best of my knowledge”) prior to submission to the  
19 AMA; and be it further

20  
21 RESOLVED, That the completed AMA-MSS Standing Committee applications be made available online  
22 (via the established mechanism for password protected information (member-only content) already  
23 deployed on the AMA Web site) within 2 weeks after the deadline, so that they may be viewed by AMA-  
24 MSS members.

Fiscal note: TBD

Received: 4/25/08

References:

1. AMA-MSS IOPs. Available at [www.ama-assn.org/ama1/pub/upload/mm/15/internal\\_oper\\_proced.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/15/internal_oper_proced.pdf).
2. A search of the past five years’ worth of national meeting handbooks (A-03 – I -07) was performed to determine if students who went on to be elected to a GC position had listed service on an AMA-MSS Standing Committee, on a Convention Committee, as a Liaison, as a student Councilor, or as a Region officer on their CV.
3. MSS 2007-2010 Operational Plan, Recommendation 9: “That in the realm of MSS Committees the MSS Governing Council should: a. Require an annual end of year 1-2 page report by each MSS committee to be kept by the AMA-MSS staff to enhance institutional memory, and b. Establish a process by which MSS committees are reviewed every three years to assess their need and efficacy, to delineate their responsibilities, and to consider the creation of needed committees.” Available at [www.ama-assn.org/ama1/pub/upload/mm/15/mss\\_plan\\_2007-2010.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/15/mss_plan_2007-2010.pdf).
4. MSS Governing Council application, requirement 3: “The elected MSS Governing Council member should be available to attend up to four Governing Council meetings of the Medical Student Section, as well as the Interim and Annual Meetings. Please acknowledge that you have discussed this time commitment and made appropriate arrangements with your dean or clinical preceptor by signing below. The signature of your dean or preceptor is required to acknowledge the time commitment involved in a Governing Council position and to verify that you are a student in good-standing with your medical school.” Available at [www.ama-assn.org/ama1/pub/upload/mm/15/gc\\_application.doc](http://www.ama-assn.org/ama1/pub/upload/mm/15/gc_application.doc).
5. AMA-MSS Digest of Policy Actions, multiple sections. Available at [www.ama-assn.org/ama1/pub/upload/mm/15/digest\\_of\\_actions.pdf](http://www.ama-assn.org/ama1/pub/upload/mm/15/digest_of_actions.pdf).

Relevant AMA and MSS policy:

**630.065MSS AMA Medical Student Section 2004-2007 Strategic Plan**

(3): In the realm of leadership, our AMA-MSS Governing Council should continue to pursue collaborative policy making in the form of ad-hoc task forces and standing committees; encourage the MSS Chair to delegate responsibility for advocacy to the Vice-Chair so that the Chair can emphasize collaborating with other organizations (e.g. AMSA, AAMC, SNMA, etc.) and serving as the public face of the MSS; encourage the MSS Member at-Large to take full responsibility for pursuing the membership goals; take steps to strengthen Regional allegiance and leadership.

**630.070MSS AMA-MSS 2007-2010 Operational Plan**

(7)(D): In the realm of Governing Council Leadership, the MSS Governing Council will: Set the goals of the AMA MSS by the end of the first GC meeting, including setting broad goals and expectations for each AMA MSS Standing Committee.

**640.013MSS AMA-MSS Standing Committees**

The AMA-MSS Governing Council will: (1) outline the creation, maintenance, and dissolution of standing and ad-hoc committees and report back at I-05; (2) handle requests for funding from MSS standing or ad-hoc committees on a case by case basis with the committee that is requesting the funding presenting a justifiable proposal, which clearly meets the Governing Council's goals, 30 days in advance of the monetary need; and (3) seek funding for two conference calls per committee per year. (MSS Rep F, A-05)

**645.022MSS Medical Student Section Policy Making Procedures:**

(1) The AMA-MSS Governing Council will: (a) encourage each standing committee to undertake a policy consolidation in one particular area relevant to that committee's background if time allows, and if so, to author a policy consolidation report for every Interim Meeting, beginning with I-06, with governing council report back at A-08; (b) encourage standing committees to study one area relevant to that committee's background, and make policy recommendations in report format once a year, if that committee does not already have an assigned study and time permits, with Governing Council report back at A-08.

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 11  
(A-08)

Introduced by: Pamella Abghari, Wayne State University School of Medicine

Subject: A Call to Further Recognize and Expedite the Nationwide Health Information Network (NHIN)

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, Access to vital health care documents on any patient's current and past medical conditions is  
2 essential, especially in acute care situations, in order for physicians to provide their patients with the  
3 proper care. Errors and duplication of services have occurred in patient care because of a lack of  
4 communication of diagnostic information, current medications and past health history within the health  
5 care system<sup>1</sup>; and

6  
7 Whereas, Significant resources are spent on duplicative diagnostic tests, prescription errors, redundant  
8 insurance claims and liability lawsuits that occur as a result of lack of information<sup>2</sup>; and

9  
10 Whereas, Designing an interoperable network to facilitate the sharing of essential health care information  
11 from differing medical centers will improve patient care and cost effectiveness across the health care  
12 system and provide physicians with a more efficient way of practicing medicine, especially in emergency  
13 situations<sup>3</sup>; and

14  
15 Whereas, Such systems will seamlessly process and incorporate incoming data from existing electronic  
16 medical records at multiple health care facilities as defined by the concept of interoperability<sup>4</sup>; and

17  
18 Whereas, The Veteran's Administration hospital system has already taken it on themselves to design such  
19 a program in order to link 5.3 million patient's records for easy access and adequate care. This universal  
20 database has created a cost-saving, safe, and effective central link between 155 hospitals, 881 clinics, 135  
21 nursing homes, and 45 rehabilitation centers nationwide<sup>5</sup>; and

22  
23 Whereas, This interoperable network will assist with circulation of records and images and provide  
24 physicians with a tracking record of current and past medications to enable safer prescription processing  
25 and more efficient documentation<sup>6</sup>; and

26  
27 Whereas, This interoperable network will enable catalog development of a multiuser database available to  
28 all health care providers at minimal (or no) cost to their establishment or place of work; and

29  
30 Whereas, This universal program will have a template form with spots created for noting critical test  
31 results, interview information, medication requests and images compatible for all viewers who may be  
32 accessing the program; and

33  
34 Whereas, The Nationwide Health Information Network (NHIN) is a network of networks built on top of  
35 an internet platform that securely connects consumers, providers, and others who use health related data  
36 and services while protecting the confidentiality of health information. The network uses shared

1 architecture, processes, and procedures to interconnect health information and the professionals who use  
2 it<sup>7</sup>; and

3  
4 Whereas, Our AMA already supports the development and use of national health information technology  
5 (H-478.995) and plans to support all efforts necessary to expedite the implementation of this process.(D-  
6 478.995). However, policy must be created to address and mandate centralized collection and access to  
7 all new and existing electronic medical records (EMR) files; and

8  
9 Whereas, Efforts through the National Coordinator for Health Information Technology (ONC) are  
10 developing, maintaining, and directing the implementation of Health and Human Services (HHS) strategic  
11 plan to guide the nationwide implementation of interoperable health information technology in both the  
12 public and private health care sectors by the year 2014<sup>8</sup>; and

13  
14 Whereas, The most feasible way to implement a universal electronic medical record program associated  
15 with an interoperable network is to unite current and future planned corporate and government based  
16 production elements. Without government input, corporate competition to develop proprietary systems  
17 such as Google Health and Microsoft Health Vault will not result in successful achievement of true  
18 interoperability<sup>9</sup>; and

19  
20 Whereas, The government's duties in relation to the database will pertain to implementation,  
21 maintenance, and system user oversight; and

22  
23 Whereas, As the number of providers who accept e-medicine reaches critical mass, more third party  
24 payers (including Medicare) are likely to recognize its efficiencies and include reimbursements for it in  
25 contracts with providers<sup>10</sup>; and

26  
27 Whereas, In an attempt to alleviate the cost barrier, on Aug. 8, 2006, the Centers for Medicaid and  
28 Medicare Services (CMS) and the Office of the Inspector General (OIG) simultaneously established rules  
29 creating an exception to the Physician's Self-Referral Law (Stark) and a new safe harbor to the Anti-  
30 Kickback Statute. They are intended to support and promote physician adoption of ePrescribing and EHR  
31 technology<sup>11</sup>; and

32  
33 Whereas, The number one goal of all physicians is always to provide their patients with the best quality of  
34 life and care, requiring negotiation between a multitude of decisions, considerations, numbers,  
35 possibilities and warnings. However, without the proper knowledge, tools and information available at  
36 the point of service (wherever that may be), health care providers are limited in what they can  
37 accomplish; therefore be it

38  
39 RESOLVED, That our AMA recognize the efforts of the Department of Health and Human Services  
40 Nationwide Health Information Network (NHIN) initiative and push for an accelerated implementation of  
41 the program earlier than 2014; and be it further

42  
43 RESOLVED, That our AMA support an initiative to unite the development of HIPAA compliant health  
44 information software between government and for-profit corporations and encourage interoperability; and  
45 be it further

46  
47 RESOLVED, That this issue be forwarded to our AMA's House of Delegates meeting in June  
48 2008.

Fiscal note: TBD

Date received: 4/25/08

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## Relevant AMA and MSS Policy:

**H-478.995 National Health Information Technology**

Our AMA supports the development, adoption, and implementation of national health information technology standards through collaboration with public and private interests, and consistent with current efforts to set health information technology standards for use by the federal government. (Res. 730, I-04)

**D-478.995 National Health Information Technology**

Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care. (Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07)

AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution 12  
(A-08)

Introduced by: Travis Meyer, Penn State University School of Medicine; Brittney Culp, Texas Tech University Health Sciences Center School of Medicine; Reid Orth, University of Texas Health Sciences Center – San Antonio; Anjali Dogra, Stony Brook University School of Medicine

Subject: One Health

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, The majority of the emerging infectious diseases, including the bioterrorist agents, are  
2 zoonoses, and the incidence of food-borne, water-borne, vector-borne and other emerging infectious  
3 diseases are substantially increasing and spreading worldwide; and  
4

5 Whereas, Zoonoses can, by definition, infect both animals and humans; and  
6

7 Whereas, By their very nature, the fields of human medicine and veterinary medicine are complementary  
8 and synergistic in confronting, controlling, and preventing zoonotic diseases from infecting across  
9 species; and  
10

11 Whereas, A multidisciplinary team of health scientists is needed to better understand, control, and prevent  
12 these contemporary public health issues; and  
13

14 Whereas, These health threats are largely created from the interface of people, animals, and animal  
15 products; thus, the veterinary and medical professions need to work together to help resolve these  
16 challenges and develop new integrated strategies that concurrently benefit both domains; and  
17

18 Whereas, Collaboration and communication between human medicine and veterinary medicine have been  
19 limited in recent decades; and  
20

21 Whereas, An initiative, often called the “One Health” initiative, is being developed to improve the lives of  
22 all species – human and animal – through the collaboration of human and veterinary<sup>1,2</sup> medicine; and  
23

24 Whereas, “One Health,” previously coined as “One Medicine” by Calvin Schwabe, aims to promote and  
25 implement close meaningful collaboration and communication between human medicine, veterinary  
26 medicine, and all allied health scientists with the goal of hastening human public health efficacy as well  
27 as advanced health care options for humans (and animals) via comparative biomedical research; and  
28

29 Whereas, The challenges of the 21st Century demand that these two professions work together; and  
30

31 Whereas, The American Veterinary Medical Association (AVMA) has formed a Task Force to develop  
32 strategies to promote collaboration between human and veterinary medicine<sup>3</sup>; and

1 Whereas, the Task Force has representation from the AMA (Dr. Larry Anderson) and a liaison to the  
2 AMA BOT (Dr. Ron Davis) and this report will be made public after being accepted by the AVMA  
3 Executive Board at its June meeting; therefore be it  
4

5 RESOLVED, That our AMA-MSS engage in dialog with the Student American Veterinary Medical  
6 Association (SAVMA) for the purpose of increasing One Health and promote collaboration with the  
7 public health and veterinary professional and educational communities; and be it further  
8

9 RESOLVED, That our AMA-MSS support the integration of One Health in medical education; and be it  
10 further  
11

12 RESOLVED, That our AMA-MSS review the AVMA One Health Initiative Task Force report and report  
13 back at I-08 regarding our MSS position on the Task Force recommendations, specifically those related to  
14 education.

Fiscal note: TBD

Date received: 4/25/08

References:

1. J. Zinsstag, et al. *Lancet* 2005; 366: 2142-2145.
2. E.P.J. Gibbs. *Veterinary Record* 2005; 157: 673-679.
3. <http://www.avma.org/onlnews/javma/jan08/080101s.asp>

Relevant AMA and MSS Policy:

**H-440.871 Collaboration Between Human and Veterinary Medicine**

Our AMA:

- (1) supports an initiative designed to promote collaboration between human and veterinary medicine;
- (2) supports joint educational efforts between human medical and veterinary medical schools;
- (3) encourages joint efforts in clinical care through the assessment, treatment, and prevention of cross-species disease transmission;
- (4) supports cross-species disease surveillance and control efforts in public health;
- (5) supports joint efforts in the development and evaluation of new diagnostic methods, medicines, and vaccines for the prevention and control of diseases across species; and
- (6) will engage in a dialogue with the American Veterinary Medical Association to discuss strategies for enhancing collaboration between human and veterinary medical professions in medical education, clinical care, public health, and biomedical research. (Res. 530, A-07)











AMERICAN MEDICAL ASSOCIATION  
MEDICAL STUDENT SECTION

Resolution Late 2  
(A-08)

Introduced by: Elizabeth Inkellis, Jamie Kearns, and Brett Youngerman, Columbia University  
College of Physicians and Surgeons

Subject: Presumed Consent for Organ Donation

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Whereas, The demand for transplantable organs continues to increase while the supply of organs available  
2 for transplant has remained fairly constant<sup>1</sup>; and

3  
4 Whereas, There are currently 98,748 waiting list candidates for organ transplantation<sup>2</sup>; and

5  
6 Whereas; Our AMA supports the development of policies that will increase the number of organ donors  
7 (E-2.155) and supports exploration of methods to increase organ donation, including the “presumed  
8 consent” modality of organ donation (H-370.996); and

9  
10 Whereas, Adoption of a presumed consent organ donation policy has been shown to increase supply of  
11 cadaveric organs in other countries such as Spain, which has the world’s highest rate of organ donation  
12 with 33.5 out of every 1 million residents<sup>3</sup>, and Austria, where the rate of organ donation quadrupled  
13 within 8 years of the implementation of a presumed consent policy<sup>4,5</sup>; and

14  
15 Whereas, Prior AMA policy has determined that it is possible for a presumed consent policy to be carried  
16 out in an ethical manner (E-2.155); therefore be it

17  
18 RESOLVED, That our AMA draft and support legislation at the federal and state levels that:

- 19 1. Establishes “presumed consent” as the idea that “deceased individuals are presumed to be organ  
20 donors unless they indicate their refusal to donate;”  
21 2. Establishes “presumed consent” as defined by E-2.155 as the model for cadaveric organ donation  
22 in the United States;  
23 3. Protects the right of families to refuse organ donation of the deceased individual; and  
24 4. Requires that refusal to donate be recorded in a manner that is easily accessible to the appropriate  
25 health care professionals.

Fiscal note: TBD

Received: 4/30/08

References:

1. Hauptman PJ, O’Conner KJ. “Procurement and allocation of solid organs for transplantation.” N Engl J Med 1997; 336: 422-431.
2. United Network for Organ Sharing, 2008. (accessed April 6, 2008 at <http://www.unos.org>)

3. Lopez-Navidad A, Caballero F. "For a rational approach to the critical points of the cadaveric donation process." *Transplant Proc* 2001; 33: 795-805.
4. Gundle K. "Presumed consent: an international comparison and possibilities for change in the United States." *Camb Q Healthc Ethics* 2005; 14: 113-118.
5. Michielsen P. "Presumed consent to organ donation: 10 years' experience in Belgium." *J R Soc Med.* 1996; 89: 663-666.

Relevant AMA and MSS Policy:

### **E-2.155 Presumed Consent and Mandated Choice for Organs from Deceased Donors**

The supply of organs for transplantation to treat end-stage organ failure is inadequate to meet the clinical need. Therefore, physicians should support the development of policies that will increase the number of organ donors. Two prominent proposals aimed at increasing organ donation would change the approach to consent for deceased donation: mandated choice and presumed consent.

Under a presumed consent model, deceased individuals are presumed to be organ donors unless they indicate their refusal to donate. Such donations would be ethically appropriate only if it could be determined that individuals were aware of the presumption and if effective and easily accessible mechanisms for documenting and honoring refusals to donate were established. Moreover, physicians could proceed with organ procurement only after verifying that there was no documented prior refusal by the decedent and that the family was unaware of any objection to donation by the decedent.

Under a mandated choice model, individuals are required to express their preferences regarding organ donation at the time of performing a state-regulated task. This contrasts with the widespread model of voluntary organ donation under which individuals are afforded an opportunity to indicate their preferences. A mandated choice model would be ethically appropriate only if an individual's choice were made in accordance with the principles of informed consent, which would require a meaningful exchange of information. Physicians could proceed with organ procurement only after verifying that an individual's consent to donation was documented.

It is not known whether implementation of ethically appropriate models of presumed consent or mandated choice for deceased donation would positively or negatively affect the number of organs transplanted. Therefore, physicians should encourage and support properly designed pilot studies, in relatively small populations, that investigate the effects of these policies. Unless there are data that suggest a positive effect on donation, neither presumed consent nor mandated choice for deceased donation should be widely implemented.

In all models, education of individuals to facilitate informed consent is requisite. (I, III, V) Issued June 1994 based on the report "Strategies for Cadaveric Organ Procurement: Mandated Choice and Presumed Consent," adopted December 1993 (*JAMA.* 1994; 272: 809-12). Updated November 2005 based on the report "Presumed Consent for Organ Donation," adopted June 2005.

### **H-370.996 Organ Donor Recruitment**

Our AMA (1) continues to urge Americans to sign donor cards; (2) supports continued efforts to teach physicians through continuing medical education courses, and the lay public through health education programs, about transplantation issues in general and the importance of organ donation in particular; (3) encourages state governments to attempt pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card.; and (4) in collaboration with all other interested parties, support the exploration of methods to greatly increase organ donation, such as the "presumed consent" modality of organ donation. (CSA Rep. D, A-81; Reaffirmed: CLRPD Rep. F, I-91; Appended: Res. 509, I-98; Reaffirmed: CSA Rep. 6, A-00; Reaffirmed: CSA Rep. 4, I-02)

REPORT OF THE MEDICAL STUDENT SECTION  
GOVERNING COUNCIL

GC Report A  
(A-08)

Subject: Medical Student Section Policy Making Procedures

Presented by: Rana Yehia, Chair

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Introduction

2  
3 At the 2006 Annual Meeting, the MSS Assembly adopted the recommendations of GC Report E – MSS  
4 Policy Making Procedures:

- 5  
6 1. That the GC encourage each standing committee to undertake a policy consolidation in one  
7 particular area relevant to that committee’s background if time allows, and if so, to author a  
8 policy consolidation report for every Interim Meeting, beginning with I-06, and that the  
9 Governing Council report back at A-08.  
10  
11 2. That the GC encourage standing committees to study one area relevant to that committee’s  
12 background, and make policy recommendations in report format once a year, if that committee  
13 does not already have an assigned study and time permits, and that the Governing Council report  
14 back at A-08.  
15  
16 3. That there be instituted a ranking/prioritization process of all adopted MSS resolutions at the  
17 completion of the MSS Assembly. This prioritization will help determine the MSS Delegate and  
18 Alternate Delegate’s focus of lobbying in the AMA-HOD.  
19  
20 4. That the MSS shall not impose a cap on the number of resolutions it sends to the AMA House of  
21 Delegates, but shall use a prioritization process to aid in determining which MSS resolutions  
22 warrant the most effort in the AMA-HOD.  
23  
24 5. That the GC create a historical record to note actions taken by the MSS on various issues each  
25 year. This historical record need not contain the actual letters written or specific persons who took  
26 an action, but will contain a record of all public actions taken by the MSS beginning with the  
27 2006-2007 GC.  
28  
29 6. That the GC formalize each post-meeting recap from the Delegate and Alternate Delegate as an  
30 official document, to be preserved as part of the MSS historical record.  
31  
32 7. That the GC work to better publicize the tracking grid by including a current version in both the  
33 Interim and Annual meeting Handbook and placing a link to the most up-to-date tracking grid in a  
34 prominent location on the Main MSS website.  
35  
36 8. That the MSS continue usage of the mandatory Resolution Checklist, as a mechanism for  
37 discerning true MSS policy versus action items that can be accomplished in another capacity.

*This document does not represent official policy of the American Medical Association (AMA).  
Refer to AMA PolicyFinder ([www.ama-assn.org/go/policyfinder](http://www.ama-assn.org/go/policyfinder)) for official policy of the Association.*

- 1 9. That our MSS Governing Council shall continue to work with the Committee on Long Range  
2 Planning and other appropriate MSS entities to explore the feasibility and desirability of  
3 implementing a Policy Hearing and other mechanisms to improve the quality of resolutions  
4 submitted to our Assembly.  
5
- 6 10. That the MSS maintain the Reaffirmation Calendar as a means of addressing important, but  
7 previously passed MSS policy.  
8
- 9 11. That when an MSS policy which has been forwarded to the HOD (but was not passed) comes up  
10 for sunseting, the MSS Delegate and MSS Alternate Delegate will consider reforwarding the  
11 item as a new HOD resolution at their discretion prior to sunset.  
12

13 This report provides a summary of MSS action to date on these recommendations.  
14

#### 15 Discussion 16

17 In the two years since the adoption of the recommendations of GC Report E-A-06, the MSS policy  
18 making process has been greatly improved. Below, we provide updates on each recommendation of GC  
19 Report E-A-06 and recommend future action that we believe will ensure the continued improvement of  
20 the MSS policy making process.  
21

- 22 1. *That the GC encourage each standing committee to undertake a policy consolidation in one*  
23 *particular area relevant to that committee's background if time allows, and if so, to author a policy*  
24 *consolidation report for every Interim Meeting, beginning with I-06, and that the Governing Council*  
25 *report back at A-08.*  
26

27 Unfortunately, due to a large volume of important work on other issues, policy consolidation has not  
28 been a high priority for this GC and its committees. Nonetheless, we believe that consolidation of the  
29 expansive MSS Digest of Policy Actions is a laudable goal that will likely improve the MSS policy  
30 making process. We believe that such consolidation could be accomplished as part of the GC's  
31 annual review of MSS policies up for sunseting. Accordingly, we recommend that the next GC  
32 undertake policy consolidation in at least one area and report back with recommendations for future  
33 policy consolidation efforts.  
34

- 35 2. *That the GC encourage standing committees to study one area relevant to that committee's*  
36 *background, and make policy recommendations in report format once a year, if that committee does*  
37 *not already have an assigned study and time permits, and that the Governing Council report back at*  
38 *A-08.*  
39

40 Over the course of the past two years, the GC has increasingly made it a priority to align its activities  
41 and those of the MSS with the AMA Agenda and with the objectives of the AMA Strategic Plan.  
42 Creating policy for the sake of creating policy diffuses the AMA's focus and resources, especially  
43 when the policy created is outside the scope of the AMA Agenda. Consequently, instead of  
44 encouraging committees to undertake policy-writing initiatives, we endorse the approach set forth by  
45 the MSS 2007-2010 Operational Plan, which encourages the GC to "establish top priorities for the  
46 MSS and strongly encourage that resolutions fulfill those priorities" (630.070MSS). When  
47 appropriate, we believe that MSS committees can still play an integral role in creating necessary  
48 policy to further the central goals of the MSS and of the broader AMA.  
49

- 50 3. *That there be instituted a ranking/prioritization process of all adopted MSS resolutions at the*  
51 *completion of the MSS Assembly. This prioritization will help determine the MSS Delegate and*  
52 *Alternate Delegate's focus of lobbying in the AMA-HOD.*  
53 4. *That the MSS shall not impose a cap on the number of resolutions it sends to the AMA House of*  
54 *Delegates, but shall use a prioritization process to aid in determining which MSS resolutions warrant*

1 *the most effort in the AMA-HOD.*

2  
3 A ranking process was established at I-06 and continued at A-07. However, due to the small number  
4 of MSS resolutions forwarded to the House of Delegates (HOD), the rankings were ultimately of little  
5 value, as the MSS Delegate and Alternate Delegate were not required to ration MSS lobbying  
6 resources.

7  
8 We believe that the implementation of the mandatory MSS Resolution Checklist has helped to limit  
9 MSS-sponsored resolutions in the HOD to those that are entirely necessary. Furthermore, the  
10 establishment of the MSS HOD Coordinating Committee (HCC) as a standing committee has greatly  
11 increased the lobbying resources at the disposal of the MSS Delegate and Alternate Delegate.  
12 Consequently, we do not believe that a resolution ranking/prioritization process for resolutions to be  
13 forwarded to the HOD is warranted at this time. However, we believe that a ranking/prioritization  
14 process should always remain an option to be employed in the event that the MSS is faced with more  
15 potential business in the HOD than the Delegate and Alternate Delegate can adequately handle.

- 16  
17 5. *That the GC create a historical record to note actions taken by the MSS on various issues each year.*  
18 *This historical record need not contain the actual letters written or specific persons who took an*  
19 *action, but will contain a record of all public actions taken by the MSS beginning with the 2006-2007*  
20 *GC.*

21  
22 See commentary on Recommendation 7.

- 23  
24 6. *That the GC formalize each post-meeting recap from the Delegate and Alternate Delegate as an*  
25 *official document, to be preserved as part of the MSS historical record.*

26  
27 After each meeting, the actions taken by the HOD on MSS-sponsored resolutions are recorded in the  
28 MSS Summary of Actions. Summary of Actions documents for every Annual and Interim meeting  
29 dating back to A-99 are now available in searchable format on the MSS Web site ([www.ama-](http://www.ama-assn.org/go/msspolicy)  
30 [assn.org/go/msspolicy](http://www.ama-assn.org/go/msspolicy)).

- 31  
32 7. *That the GC work to better publicize the tracking grid by including a current version in both the*  
33 *Interim and Annual meeting Handbook and placing a link to the most up-to-date tracking grid in a*  
34 *prominent location on the Main MSS Web site.*

35  
36 In its current format, the MSS policy tracking grid is too dense for general consumption, as its details  
37 often overwhelm the more relevant information likely to be of interest to most members.

38 Furthermore, its length (20-25 pages) makes impractical its distribution in printed form. We  
39 recommend that instead of a comprehensive policy tracking grid, the MSS institute a grid similar in  
40 format to the HOD's "Implementation of Resolutions and Report Recommendations," which is  
41 published at each national meeting and provides succinct status updates on resolutions and report  
42 recommendations adopted by the HOD at the previous meeting. This grid would be made available  
43 online and at each MSS national meeting; members seeking detailed information could always  
44 contact the GC for more information. We believe that archiving these status updates will satisfy the  
45 intentions of the "historical record" called for in Recommendation 5.

- 46  
47 8. *That the MSS continue usage of the mandatory Resolution Checklist, as a mechanism for discerning*  
48 *true MSS policy versus action items that can be accomplished in another capacity.*

49  
50 Continued improvement to and strict enforcement of the mandatory resolution checklist has resulted  
51 in the introduction of fewer resolutions with goals that could be accomplished by non-policy making  
52 mechanisms. Additionally, the creation of an online Governing Council Action Form ([www.ama-](http://www.ama-assn.org/ama/pub/category/16173.html)  
53 [assn.org/ama/pub/category/16173.html](http://www.ama-assn.org/ama/pub/category/16173.html)) has provided yet another means by which Section  
54 membership can accomplish goals that might otherwise have been unnecessarily pursued through the

1 MSS policy making process.

- 2
- 3 9. *That our MSS Governing Council shall continue to work with the Committee on Long Range*  
4 *Planning and other appropriate MSS entities to explore the feasibility and desirability of*  
5 *implementing a Policy Hearing and other mechanisms to improve the quality of resolutions submitted*  
6 *to our Assembly.*

7

8 The GC has not expressly explored the concept of Policy Hearings. However, the implementation  
9 and strict enforcement of the mandatory Resolution Checklist has greatly improved the quality and  
10 relevance of MSS resolutions. Additionally, HCC, in its new role as a standing committee, has  
11 worked with all resolution authors to further improve the quality of resolutions submitted for  
12 consideration by the MSS Assembly. Consequently, at this time we do not believe that further  
13 exploration of Policy Hearings or other mechanisms to improve the quality of submitted resolutions is  
14 necessary.

- 15
- 16 10. *That the MSS maintain the Reaffirmation Calendar as a means of addressing important, but*  
17 *previously passed MSS policy.*

18

19 The MSS has continued its use of the Reaffirmation Calendar as a means of addressing items of  
20 business that reaffirm existing AMA and/or MSS policy. Beginning with I-07, the MSS mimicked  
21 the formal Reaffirmation Calendar format employed by the House of Delegates. Because the new  
22 format led to some confusion within the Assembly, we recommend that future GCs educate the  
23 Section, specifically the representatives to the MSS Assembly, on the purpose and functioning of the  
24 MSS Reaffirmation Calendar.

- 25
- 26 11. *That when an MSS policy which has been forwarded to the HOD (but was not passed) comes up for*  
27 *sunsetting, the MSS Delegate and MSS Alternate Delegate will consider reforwarding the item as a*  
28 *new HOD resolution at their discretion prior to sunset.*

29

30 When the GC reviews MSS policy up for sunsetting, the MSS Delegate and Alternate Delegate  
31 consider reforwarding items previously forwarded to but not adopted by the HOD. Although the  
32 MSS Delegates and Alternate Delegates have not yet found it necessary to do so, we believe that this  
33 reforwarding option is a potentially valuable policy making device that should be preserved.

34

35 Recommendations

36

37 Your Governing Council recommends that the following be adopted and that the remainder of this report  
38 be filed:

- 39
- 40 1. That 645.022MSS – Medical Student Section Policy Making Procedures be rescinded.
- 41
- 42 2. That, as part of its annual review of MSS policies set to sunset at I-08, the MSS Governing  
43 Council undertake policy consolidation for at least one issue, and report back with  
44 recommendations for future policy consolidation efforts.
- 45
- 46 3. That, when deemed necessary by the MSS Delegate and Alternate Delegate, the MSS employ a  
47 ranking/prioritization process for MSS resolutions intended to be forwarded to the AMA House  
48 of Delegates.
- 49
- 50 4. That the MSS Governing Council provide the MSS with updates on actions taken on resolutions  
51 and report recommendations adopted by the MSS Assembly, similar in format to the HOD’s  
52 “Implementation of Resolutions and Report Recommendations” documents, and that these  
53 updates be archived as an historical record of GC actions.

- 1       5. That the MSS continue to use a Reaffirmation Consent Calendar, modeling it in the style of the  
2       House of Delegates Reaffirmation Consent Calendar.
- 3
- 4       6. That the MSS Governing Council educate the Section, specifically representatives to the MSS  
5       Assembly, on the purpose and functioning of the MSS Reaffirmation Consent Calendar.
- 6
- 7       7. That the MSS continue to use and enforce the mandatory MSS Resolution Checklist.
- 8
- 9       8. That when MSS policy comes up for sunseting, the MSS Delegate and Alternate Delegate, at  
10      their discretion, consider reforwarding to the House of Delegates MSS policy that was previously  
11      forwarded but not adopted.

REPORT OF THE MEDICAL STUDENT SECTION  
GOVERNING COUNCIL

GC Report B  
(A-08)

Subject: Use of Radiofrequency Identification Tags in Surgical Sponges

Presented by: Rana Yehia, Chair

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

---

1 Introduction

2  
3 At the 2006 MSS Interim Meeting, Resolution 12 – Usage of Radiofrequency Identification (RFID) Tags  
4 for Identification of Surgical Gauze Sponges was referred for report:

5  
6 RESOLVED, That our AMA encourage the use of RFID technology as an appropriate means of  
7 improving patient safety, decreasing surgical incidence of retained sponges, and reducing  
8 subsequent sequelae (New AMA Policy).

9  
10 The MSS Governing Council enlisted the aid of the 2007-2008 MSS Committee on Medical Ethics to  
11 research and complete this report and fully endorses the Committee’s work.

12  
13 Background

14  
15 *The Problem*

16 Surgical sponge retention remains one of the most common surgical errors. In 2000, 1 in 10,000  
17 surgeries resulted in a foreign object being left in the body, with surgical sponges accounting for  
18 approximately 67 percent of these foreign objects. Moreover, a recent study found the incidence of  
19 surgical sponge retention to be as high as 1 in 1,000-1,500 abdominal surgeries.<sup>1</sup> The consequences of  
20 retained sponges, such as sepsis, internal obstruction, fistula formation, and other sequelae, cause  
21 unnecessary morbidity and mortality and often require the use of restorative procedures. Indeed, in 2000,  
22 surgical sponge retention resulted in approximately four extra days in hospital per incident and a total of  
23 57 deaths. In addition to harm caused to the patient, sponge retention can result in professional  
24 complications, such as malpractice lawsuits, for the health care workers involved.

25  
26 Currently, before closure of surgical incisions, individuals working in the operating room are supposed to  
27 count instruments and sponges. The standard procedure, set by the Association of Operating Room  
28 Nurses, requires that sponges be detectable by radiography and be counted once before and twice after  
29 surgery. If the before- and after- counts do not match, radiography or manual reexploration must be  
30 performed to locate the missing objects. Some institutions perform a post operative X-ray to look for  
31 retained sponges; however, this practice not only exposes the patient to radiation, but also does not have a  
32 perfect detection rate. Still other institutions either have no policy or use screening procedures only when  
33 there exists a mismatch in pre- and post-operative sponge counts.

34  
35 Most cases resulting in retained instruments or sponges are believed to be the result of objects going  
36 undetected rather than counting procedures not being followed. Nevertheless, procedural measures are

1 subject to human error and have been shown to be less reliable in emergency situations and in cases  
2 where procedural changes occur during the operation.<sup>1</sup>

### 3 *A potential solution*

4 The AMA believes that there exists an ethical responsibility to study and prevent medical errors (E-8.121,  
5 refer to Appendix 1 for all AMA policy cited in this report). The use of gauze sponges embedded with  
6 radio frequency identification (RFID) tags may provide better outcomes for reducing or eliminating  
7 instances of retained surgical sponges. Many studies show that human counts during surgical operations  
8 often result in errors where instruments and sponges are left within the patient's body. The use of RFID  
9 technology may help to remove the human error factor, thereby improving patient safety.

10  
11  
12 The AMA has studied the medical and ethical implications of the use of RFID in humans as recently as  
13 A-07 (D-480.982), concluding that the efficacy and security of RFID technology have not been  
14 established and that therefore physicians should proceed with caution (H-140.867). However, in the time  
15 since the AMA conducted its study, more information has become available concerning this now-FDA-  
16 approved technology. We believe that given the evidence available, the AMA should support the use of  
17 RFID technology as a means by which to prevent the retention of surgical sponges.

### 18 RFID Technology and Surgical Sponge Retention

#### 19 *What is RFID?*

20  
21 RFID is a generic term for technologies that use radio waves to automatically identify people or objects.  
22 There are several methods of identification, but the most common is to store a serial number that  
23 identifies a person or object, and perhaps other information, on a microchip that is attached to an antenna.  
24 (The chip and antenna together are called an RFID transponder or an RFID tag.) The antenna enables the  
25 chip to transmit the identification information to a reader, which converts the radio waves reflected back  
26 from the RFID tag into digital information that is passed on to computers that can make use of it.<sup>2</sup>

#### 27 *Reasons for support*

28  
29 RFID is a proven and safe technology that has been used for the past 20 years in multiple applications,  
30 including the embedding of RFID tags in more than 50 million pets. The benefits of RFID include:

- 31 • Passive: Non emitting tag and contains no battery
- 32 • Small: RFID tag is the size of a penny
- 33 • No line-of-sight required to detect sponges
- 34 • Can read multiple sponges simultaneously
- 35 • Can't count the same sponge twice<sup>3</sup>

36  
37  
38  
39 The use of barcode and other line-of-sight labeling techniques to account for surgical sponges and devices  
40 can lead to improved patient safety when used appropriately. However, studies suggest that RFID may  
41 hold advantages over barcoding, as RFID-tagged sponges and instruments can be tracked even inside the  
42 body cavity, while barcoded sponges and instruments can not.<sup>4</sup> Investigations into the efficacy of RFID  
43 technology in reducing the incidence of retained sponges are promising, with one initial clinical  
44 evaluation yielding 100% detection accuracy with no false positives or negatives.<sup>5</sup> In June 2007, the FDA  
45 approved the ClearCount SmartSponge system, the first RFID-based sponge counting system.<sup>6</sup>

46  
47 In addition to being safe, effective, and a superior option to other sponge accounting techniques, the use  
48 of RFID technology is cost-effective. RFID technology avoids the cost of post operative X-rays and  
49 search time. Perhaps more significantly, however, the use of RFID technology may greatly alleviate the  
50 costs of litigation resulting from retained sponges. One study examined just 40 cases of retained sponges  
51 (of which 76 percent were due to falsely correct sponge counts) and found that the subsequent litigation  
52 costs (indemnity payments plus legal fees) were in excess of \$2.6 million, or more than \$68,000 per  
53 incident.<sup>7</sup>

1 By comparison, the cost of a case of RFID-tagged surgical sponges that could have prevented retention is  
2 just \$2.82 more than the cost of a case of standard surgical sponges (\$71.06 vs. \$68.24). A study  
3 examining the cost-effectiveness of RFID technology found that the majority of the cost for standard  
4 sponges was related to operating-room time necessary for nurses to manually count the sponges, whereas  
5 for RFID-tagged sponges, the largest cost component was for purchasing costs. Overall, the incremental  
6 cost effectiveness ratio was an impressive \$41,704.<sup>8</sup>

7  
8 Further support for the use of RFID technology as a means to prevent sponge retention is found in the  
9 American College of Surgeons guidelines for prevention of retained foreign bodies after surgery, which  
10 include an explicit recommendation for the employment of radiofrequency detection technology to ensure  
11 that no unintended items are left in the operative field.<sup>9</sup>

### 12 *Reasons for dissent*

13 Although the use of RFID technology to detect retained sponges has been shown to be safe, effective, and  
14 cost effective, there remain arguments against this technology on the basis of its efficacy and safety. For  
15 example, RFID systems generally use a handheld wand to detect tagged sponges and instruments.  
16 Unfortunately, the accurate detection of retained sponges depends to some extent on wand-using  
17 techniques, as the detection wand must be held a specific distance from the body and must cover the  
18 entire surface area of the surgical site. Consequently, accurate detection requires a certain level of skill  
19 that may or may not exist in actual clinical practice.<sup>5</sup>

20  
21 In addition to difficulties with the detection wand, the body mass index of a patient may play a factor in  
22 the detection of retained sponges. Furthermore, an investigation using porcine subjects revealed that early  
23 RFID technology was unable to accurately detect sponges once they were emerged in water.<sup>10</sup> Failure to  
24 detect sponges under these circumstances is critical because these circumstances mimic the sponge being  
25 emerged in blood at the patient's surgical site. Second generation RFID technology was more accurate  
26 for sponges emerged in water. However, significant research on the practical application of these results  
27 is not currently available.

28  
29 From a purely procedural perspective, the use of RFID technology may still be prone to human error, as  
30 detection can not take place until the very final step of the operation, lest previously detected and  
31 accounted for sponges remain in the body cavity.

32  
33 Finally, from a safety perspective, a recently published Associated Press article cites research claiming  
34 that RFID implants actually contributed to the formation of cancer in animal models.<sup>11</sup>

35  
36  
37 AMA policy requires evidence-based medicine to be used in determining useful safety standards  
38 whenever possible (H 450.948), and unfortunately, although FDA-approved, studies using RFID tags are  
39 conflicting, and may be of inadequate quality to determine new patient safety practices.

### 40 Conclusion

41  
42 Considering that the American College of Surgeons has already recommended the use of RFID  
43 technology for preventing retained surgical sponges, and the FDA has recently provided its approval to  
44 the first RFID-based sponge counting system, the AMA would be in order to provide its support as well.  
45 Patient safety is an important concern for the AMA, and support for technology that would reduce the  
46 incidence of retained sponges would further the AMA's devotion to new practices to ensure safety  
47 standards are met. However, current studies on the use of RFID technology are limited, somewhat  
48 conflicting, and often of insufficient quality to change the standards of care. Therefore, the use of RFID  
49 technology should not be approved as a replacement for human counts and other sponge-accounting  
50 techniques in the operating room, but should instead be perceived as one acceptable option to enhance  
51 patient safety. The study of RFID chips in humans has already been promoted by the AMA, and the  
52

1 results of such studies shall further delineate the AMA's stance on the use of RFID technology to reduce  
2 the number of retained surgical sponges.

3  
4 Recommendation

5  
6 Your MSS Governing Council recommends that the following be adopted in lieu of MSS Resolution 12-I-  
7 06 and that the remainder of this report be filed:

- 8  
9 1. That our AMA support the use of RFID technology as a means by which to prevent the retention  
10 of surgical sponges in order to improve patient safety and reduce subsequent sequelae. (New  
11 HOD Policy)

12  
13 Acknowledgements

14  
15 The MSS Committee on Medical Ethics is Chaired by Brittney Culp and Vice Chaired by Jason Rafferty.  
16 The Committee is composed of Anjali Patel, Jesse Kresak, Elizabeth Hay, and Grant Reed.

17  
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### **Appendix 1: Relevant AMA Policy**

#### **H-140.867 Radio Frequency ID Devices in Humans**

Radio frequency identification (RFID) devices may help to identify patients, thereby improving the safety and efficiency of patient care, and may be used to enable secure access to patient clinical information. However, their efficacy and security have not been established. Therefore, physicians implanting such devices should take certain precautions:

- (1) The informed consent process must include disclosure of medical uncertainties associated with these devices.
- (2) Physicians should strive to protect patients' privacy by storing confidential information only on RFID devices with informational security similar to that required of medical records.
- (3) Physicians should support research into the safety, efficacy, and potential non-medical uses of RFID devices in human beings. (CEJA Rep. 5, A-07)

#### **D-480.982 RFID Labeling in Humans**

Our AMA will study the medical and ethical implications of the use of radio frequency identification chips in humans. (Res. 6, A-06)

#### **H-335.965 Patient Safety**

Our AMA: (1) continues its advocacy efforts in the area of patient safety and work to promote a meaningful long-term approach to ensure greater patient safety in the delivery of health care in our nation; (2) will work in collaboration with the National Patient Safety Foundation, national medical specialty societies, state and local medical societies, other provider groups and a broad range of public and private organizations to continually advance efforts to improve patient safety through educational activities and all other available means to discover and promote "best practices" in the delivery of health care services; (3) continues to advance non-punitive, evidenced-based health systems error data collection as well as strong legal protections for participants in safety programs. At a minimum, these protections must ensure that all information reported or otherwise gathered in the process of patient safety and error reporting programs (including any data, report, memorandum, analysis, statement, or other communication) intended either for internal use, or to be shared with others solely for the same purposes, remain confidential and not be subject to discovery in legal proceedings. Such protections must extend from the time of reporting to post-incident review activities and with regard to the repositories of identifiable data from such reporting programs; (4) continues to call for a central role for the Agency for Healthcare Research and Quality (AHRQ) in coordinating the multifaceted, multi-industry national patient safety initiative envisioned by the AMA. The AHRQ must have sufficient funding to carry out research and development activities to support and advance public and private patient safety initiatives across the nation; and (5) continues to help us inform our patients and the public in general concerning on-going efforts to improve quality and reduce errors in medical care. (Sub. Res. 202, A-00; Reaffirmed: BOT Rep. 13, I-00; Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-05)

#### **H-450.948 Support of Patient Safety Aspects of JCAHO**

AMA policy is that evidence-based medicine be used to determine useful safety standards whenever possible. (Res. 530, A-04)

#### **E-8.121 Ethical Responsibility to Study and Prevent Error and Harm**

In the context of health care, an error is an unintended act or omission, or a flawed system or plan, that harms or has the potential to harm a patient. Patient safety can be enhanced by studying the circumstances surrounding health care errors. This can best be achieved through a legally protected review process, which is essential for reducing health care errors and preventing patient harm. (1) Because they are uniquely positioned to have a comprehensive view of the care patients receive, physicians must strive to ensure patient safety and should play a central role in identifying, reducing, and preventing health care errors. This responsibility exists even in the absence of a patient-physician relationship. (2) Physicians

should participate in the development of reporting mechanisms that emphasize education and systems change, thereby providing a substantive opportunity for all members of the health care team to learn. Specifically, physicians should work with other relevant health care professionals to: (a) Establish and participate fully in an effective, confidential, and protected error-reporting mechanism (b) Develop means for objective review and analysis of reports regarding errors, and to conduct appropriate investigations into the causes of harm to a patient (c) Ensure that the investigation of causes of harm, and the review and study of error reports result in preventive measures that are conveyed to all relevant individuals (d) Identify and promptly report impaired and/or incompetent colleagues so that rehabilitation, retraining or disciplinary action can occur in order to prevent harm to patients (3) Physicians must offer professional and compassionate concern toward patients who have been harmed, regardless of whether the harm was caused by a health care error. An expression of concern need not be an admission of responsibility. When patient harm has been caused by an error, physicians should offer a general explanation regarding the nature of the error and the measures being taken to prevent similar occurrences in the future. Such communication is fundamental to the trust that underlies the patient-physician relationship, and may help reduce the risk of liability. (4) Physicians have a responsibility to provide for continuity of care to patients who may have been harmed during the course of their health care. If, because of the harm suffered under the care of a physician, a patient loses trust in that physician, the obligation may best be fulfilled by facilitating the transfer of the patient to the care of another physician. (5) Physicians should seek changes to the current legal system to ensure that all errors in health care can be safely and securely reported and studied as a learning experience for all participants in the health care system, without threat of discoverability, legal liability, or punitive action. (I, II, III, IV, VIII) Issued December 2003 based on the report "Ethical Responsibility to Study and Prevent Error and Harm in the Provision of Health Care," adopted June 2003.

REPORT OF THE MEDICAL STUDENT SECTION  
GOVERNING COUNCIL

GC Report C  
(A-08)

Subject: Liability Coverage for Medical Students Completing Extramural Electives  
Presented by: Rana Yehia, Chair  
Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

---

1 Introduction  
2

3 At the 2007 MSS Annual Meeting, Resolution 11 – Standardization of Medical Liability Coverage  
4 Requirements for Medical Students was referred for report:  
5

6 RESOLVED, That the AMA work with the American Osteopathic Association to direct medical  
7 schools to explore ways to provide short term additional medical liability coverage to students to  
8 allow them to complete a visiting rotation at any institution that requires greater liability coverage  
9 than that provided by the medical school; and be it further  
10

11 RESOLVED, That the AMA direct the Council on Medical Education to study and determine  
12 why medical student medical liability coverage requirements are so high, and report back at A-  
13 08; and be it further  
14

15 RESOLVED, That the AMA direct the Council on Medical Education to study and determine the  
16 most effective policy that would allow all students to complete at least one 4-week rotation at an  
17 institution requiring extra medical liability coverage without paying excessive out of pocket fees  
18 for the additional coverage; and be it further  
19

20 RESOLVED, That this resolution be forwarded immediately to the AMA House of Delegates.  
21

22 The MSS Governing Council enlisted the aid of the 2007-2008 MSS Committee on Medical Education to  
23 research and complete this report and fully endorses the Committee's work.  
24

25 Background on Medical Liability  
26

27 Medical liability insurance covers the cost to medical providers of settlements or liability awards in the  
28 event of malpractice lawsuits. Medical liability coverage consists of two distinct components that  
29 represent coverage for a single event and for aggregate coverage. Underwriters of medical liability  
30 coverage provide a package that includes both single incident and aggregate coverage limits, generally  
31 represented by two numbers that describe the respective limits (e.g. \$25,000/\$50,000).<sup>1</sup>  
32

33 Currently, medical providers at all levels of training must carry some level of medical liability coverage,  
34 since any and all members of a health care team may be included as defendants in a malpractice suit. The  
35 mandate for carrying coverage is dictated by a variety of bodies, including hospitals, states, and academic  
36 institutions. As a consequence, the cost of medical liability coverage has several driving factors that are  
37 independent of the traditional driving factors of insurance costs, such as market factors and dispersion of  
38 risk.

*This document does not represent official policy of the American Medical Association (AMA).  
Refer to AMA PolicyFinder ([www.ama-assn.org/go/policyfinder](http://www.ama-assn.org/go/policyfinder)) for official policy of the Association.*

1 *State and other coverage requirements*

2 Some states (Colorado, Connecticut, Florida, Kansas, Massachusetts, Missouri, Pennsylvania, and  
3 Wisconsin) set minimum requirements for professional liability insurance.<sup>2</sup> The required minimum  
4 liability coverage ranges from \$100,000/\$300,000 to \$1 million/\$3 million. Some of these state  
5 requirements have exceptions, such as in Missouri, where the mandated coverage level is required only of  
6 physicians who practice in a hospital in a county with a population greater than 75,000, and who are not  
7 already covered by hospital liability policies.

8  
9 Other states (Indiana, Louisiana, Nebraska, New Mexico, New York, and Wyoming) require a physician  
10 to carry minimum levels of coverage if he or she desires to qualify for the benefits of liability reforms,  
11 such as caps on damages.<sup>2</sup> The limits in these states encompass an even wider range, from  
12 \$50,000/\$50,000 to \$1.3million/\$3.9 million. In these states, if a practitioner has coverage to the  
13 recommended levels, any additional payout in a liability case is paid for out of a patient compensation  
14 fund.

15  
16 Other entities requiring minimum levels of liability insurance include hospitals and health plans.<sup>1</sup> In  
17 order to receive hospital privileges, hospitals generally require a minimum amount of coverage.  
18 Similarly, health plans generally require proof of liability coverage for physician participation.

19  
20 *The medical liability crisis*

21 The AMA has identified three recent medical liability “crises,” with one in the 1970s, one in the 1980s,  
22 and one currently.<sup>3</sup> The current crisis is attributed to the rapidly escalating sizes of claims in those states  
23 that have not yet enacted medical liability reform. Even taking into account states that have adopted  
24 reforms, the national median medical liability jury award increased from \$157,000 to \$439,400 in just  
25 seven years, between 1997 and 2004. Similarly, the average award rose from \$347,134 to \$606,907 over  
26 the same period of time. This increase in medical liability outpaces other tort awards; medical liability  
27 costs rose by 8.5% between 2003 and 2004, significantly higher than other U.S. tort costs, which rose just  
28 5.6%.

29  
30 Some have argued that the current medical liability crisis is due to natural economic cycles. However, the  
31 U.S. Department of Health and Human Services has asserted that if this were the case, all states would be  
32 affected equally, but this has not proven to be the case.<sup>4</sup> The recent crisis has created a divide between  
33 those states with rapidly escalating liability costs, and those with regulations that keep costs relatively  
34 under control. This divide has been paralleled by changes in the numbers of new physicians in a  
35 particular state, depending on which category the state falls into. For instance, Kentucky, considered a  
36 state “in crisis,” lost nearly 1,200 physicians between 2000 and 2002, with one third of those relocating to  
37 neighboring states.<sup>4</sup> Many of these physicians were those in “high-risk” practices requiring higher  
38 coverage. Between 2001 and 2004, the state lost 36% of its total number of practicing neurosurgeons,  
39 29% of its general surgeons, and 25% of its obstetricians. Meanwhile, states that have enacted liability  
40 reform have seen increases in licensure of these high-risk specialists, as in Texas. According to the Texas  
41 Medical Board, in 2006, 92 obstetricians applied for licensure, and between January and May of 2007  
42 alone, 23 neurosurgeons sought licensure, both setting records.<sup>5</sup> Furthermore, in 2006, 86% of those  
43 seeking licensure in Texas were out-of-state applicants.

44  
45 *Medical education and the medical liability crisis*

46 Practicing physicians are not the only medical professionals making medical practice decisions based on  
47 liability coverage concerns. Residents and even students are in fact making decisions on specialty choice  
48 and states in which to practice based on the current medical liability environment. In recent years,  
49 medical liability has been an increasing concern for medical residents. In 2001, only 15% of residents  
50 considered medical liability issues a “top concern,” however, by 2003, 62% of residents reported that  
51 these issues were a top concern, trumping all other concerns.<sup>3</sup> A survey of physician residents in  
52 Pennsylvania in 2005 found that nearly one third of them were planning to leave the state following  
53 residency specifically because of the lack of affordable malpractice insurance.<sup>3</sup> The effect of medical

1 liability concerns has even filtered down to the student level, as shown by a recent AMA survey in which  
2 nearly half of third- and fourth-year medical students reported that medical liability was a factor in  
3 specialty choice. In the same survey, 39% of students indicated that state medical liability environment  
4 was a factor in deciding where to pursue residency training.<sup>6</sup>

5  
6 While the differences in medical liability costs across states and specialties are already affecting decision  
7 making of those in the medical field at all levels of training, one area that has been largely ignored is the  
8 effect these differences have on medical training itself, particularly as it pertains to students who wish to  
9 complete specialized rotations away from their home institutions (extramural electives). Although many  
10 medical schools provide similar liability coverage amounts of \$1 million/\$3 million, there are schools that  
11 provide significantly less coverage (as little as \$25,000/\$75,000 in Texas), forcing some students to  
12 confront a significant gap in coverage as they plan extramural electives. While some students respond by  
13 purchasing additional coverage, other students limit their elective choices to schools that either don't  
14 require any specific coverage or that require levels similar to the students' home institutions. A  
15 significant proportion of students completing extramural electives do so in the hopes of eventually  
16 entering residency at the host institution. Consequently, extramural elective decisions represent yet  
17 another point at which the financial implications of the medical liability environment influence students'  
18 decisions on the state and/or specialty in which to train and, ultimately, in which to potentially practice.

19  
20 *Student medical liability coverage for extramural electives*

21 In many instances, a student's home institution is responsible for the medical liability coverage of a  
22 student completing an extramural elective. However, while a student's home institution is responsible for  
23 providing the coverage, it is generally the host institution that determines the mandatory level of coverage  
24 a student must carry. There are exceptions on both sides of the matter, however.

25  
26 The University of Alabama does not accept the home coverage of any visiting student, instead requiring  
27 all visiting students to purchase temporary coverage through the University of Alabama. This coverage is  
28 inexpensive, costing \$25 per student per rotation regardless of home coverage.<sup>7</sup> Meanwhile, a few  
29 institutions such as Creighton University and the University of Mississippi have umbrella coverage that  
30 covers all students, including any visiting students completing rotations there, regardless of home liability  
31 coverage.<sup>8,9</sup> Other institutions such as Ohio State University, while asking for proof of liability coverage  
32 at a student's home school, do not ask for or mandate any specific level of coverage.<sup>10</sup> Additionally, in a  
33 few instances, while a school might mandate a certain level of coverage for its own students, it is willing  
34 to waive coverage or accept lower levels of coverage for students coming from institutions with much  
35 lower coverage.

36  
37 While an informal survey found that most schools provide coverage of \$1 million/\$3 million to home  
38 students and thus require the same levels of coverage for visiting students, there are schools that have  
39 significantly lower levels of coverage. This situation is most prevalent in Texas. Both Texas Tech  
40 University and Texas A&M University provide only \$25,000/\$75,000 coverage, and until recently had no  
41 plan in place for students to obtain additional coverage.<sup>11,12</sup> Recently, Texas A&M arranged for students  
42 to be able to buy into additional coverage if desired, and Texas Tech is looking into similar arrangements.  
43 However, representatives from both schools have communicated that students have at times had  
44 significant difficulties with pursuing extramural electives at some host institutions with significantly  
45 higher coverage requirements.

46  
47 Meanwhile, all of the University of Texas (UT) system schools have the same student coverage of  
48 \$25,000/\$75,000, but students do have the option of purchasing higher levels of coverage for a month at a  
49 time under the UT Professional Medical Liability Benefit Plan. According to a representative from UT  
50 Houston, the cost of this additional coverage generally ranges from \$40 to \$200, depending on the  
51 location of the extramural elective. However, there have been problems with this supplemental UT  
52 coverage at host institutions that require the UT plan to pay into a host state-funded coverage plan to

1 transfer coverage while the student is rotating elsewhere. This has reportedly been a problem at times in  
2 Kansas, New Mexico, Louisiana, and Iowa.<sup>13</sup>

3  
4 Gaps in liability coverage have been equally problematic for osteopathic students completing extramural  
5 electives at allopathic institutions. Texas College of Osteopathic Medicine (TCOM), like many other  
6 schools in Texas, provides coverage of only \$25,000/\$75,000. While TCOM provides information to  
7 students on purchasing additional coverage, it does not have any specific program set up to purchase  
8 additional coverage through the school. Consequently, the cost for a year of additional coverage to the  
9 level of \$1 million/\$3 million is estimated at \$1,500 for a single student. Each year approximately 10-15  
10 students purchase this additional coverage. Unfortunately, however, there have been instances in which  
11 this additional private insurance is still not accepted by another institution since it is not arranged directly  
12 through the home school.<sup>14</sup>

13  
14 Louisiana State University also has lower coverage for its students, with levels of \$500,000/\$1.5 million.  
15 Students at this institution have also been limited in their extramural elective selection, though they also  
16 have the option of purchasing additional coverage. In addition, as with TCOM, students purchasing  
17 additional coverage via a private insurer instead of through their home or host institution have at times  
18 been confronted with difficulties with host institutions not accepting the additional coverage.<sup>15</sup>

19  
20 Other institutions have additional requirements or recommendations specific to the institution. For  
21 example, the branches of the State University of New York have a policy requiring students to either  
22 rotate at an institution with which they already have an affiliation, or else fill out an affiliate agreement  
23 form and have the location approved far in advance.<sup>16, 17</sup> Without the affiliate agreement in place, the  
24 student's home coverage does not transfer when doing a rotation at another institution.

25  
26 An informal review found that there have been a few instances in which institutions have considered  
27 increasing requirements beyond \$1 million/\$3 million, which in many cases exceeds state-mandated  
28 coverage levels for physicians. At least one institution has considered requiring additional coverage only  
29 through rotations in specific, high-risk specialties, while another location reportedly considered requiring  
30 \$3 million/\$5 million coverage for all students visiting the institution. It is unclear whether any  
31 institutions are requiring \$3 million/\$5 million coverage at this time, but it nonetheless seems to be a  
32 possibility that has been considered.

### 33 34 *Appropriate levels of liability coverage for medical students*

35 There is little in the scholarly literature that specifically addresses the issue of appropriate levels of  
36 liability coverage for students or whether students should be required to carry coverage equal to that of  
37 the physicians who are responsible for them. One of the few articles that touched upon this issue  
38 examined the standard of conduct to which medical students should be legally held during their training.  
39 It concluded that

40 "any persons holding themselves to be practitioners, including students and residents, should be  
41 held to the standard of conduct of a practicing professional. . . A significant reason that students  
42 and residents are being held . . . to the same standard of conduct as practicing professionals is that  
43 they are providing care under the supervision of licensed, experienced faculty . . . Supervising  
44 faculty have a parallel duty to those patients to provide adequate levels of supervision to ensure  
45 that such a [nationally recognized] standard be met."<sup>18</sup>

46 This argument could be interpreted in diametrically opposite ways as it pertains to the liability of a  
47 student under a supervising professional. Interpreted one way, it could be argued that since students are  
48 held to the same level of conduct as a supervising professional, they should be held equally liable in a  
49 court of law. Alternatively, because the standard of conduct is the same precisely because students are  
50 under supervision, it could be argued that the weight of the liability should fall solely on the supervising  
51 professional. While the truth likely lies somewhere in the middle, the legal standard of the extent to  
52 which students should be or are found liable in a court of law has not been directly examined.

## Relevant Policy and Recommendations from National Bodies

### *Liaison Committee on Medical Education (LCME)*

LCME accreditation standards do not include specific requirements or guidelines for medical schools regarding either the levels of liability insurance provided to their own medical students or the levels required of visiting students. The only reference to liability insurance in the LCME standards pertains to visiting students, stating that “The accepting school should verify the credentials of visiting students . . . [which] allows the school accepting them to establish protocols or requirements for . . . liability protection comparable to those of their own enrolled students.”<sup>19</sup>

### *Association of American Medical Colleges (AAMC)*

While AAMC has put forth recommendations pertaining to liability coverage for medical students, these recommendations do not specifically address coverage limits or inconsistencies in those limits among medical schools. AAMC recommends that “[s]chools should provide sufficient liability insurance for medical students to complete all school sponsored aspects of their medical education and training.”<sup>19</sup> However, whether these school-sponsored aspects of medical education apply to a student’s ability to complete extramural electives is left open-ended. AAMC’s recommendations regarding visiting students’ coverage at an away institution mirror the LCME standards: “A host school should ascertain that any visiting student coming to the school for a visiting rotation is covered for medical liability and/or malpractice. Some host schools may incorporate the visiting student into the host school’s or medical center’s group medical malpractice coverage. The host school is expected to document the coverage prior to receiving the student for an elective rotation. It is recommended that the host school’s application form for visiting students request information and documentation on this topic.”<sup>20</sup>

It should be noted that AAMC does provide an online compendium of institutions that accept visiting students for electives, with some information regarding requirements and contacts. Unfortunately, the compendium’s value is somewhat limited as it pertains to students concerned with medical liability coverage issues in that not all schools provide information regarding medical liability coverage requirements for visiting students. The compendium’s utility to students concerned with medical liability coverage issues is further limited by its search function, which does not permit searches that take into account host institution liability coverage requirements.<sup>21</sup>

### *American Medical Association (AMA)*

While the AMA has significant policy regarding liability insurance for professionals, it has little policy that directly addresses liability insurance coverage for medical students. The AMA does recommend that “medical schools and directors of residency programs assist students and residents to understand and apply the determinants of sound risk management to clinical practice” (H-435.997). However, this is the only direct mention of medical schools with respect to medical liability.

The AMA also has policy regarding coverage requirements that are above and beyond limits imposed by the state: “The AMA finds unreasonable the demand by any hospital or third party payer that their providers carry professional liability coverage in excess of the minimum mandated of physicians by state law” (H-435.966). This policy position could potentially be broadly applied to schools, some of which serve as third parties requiring visiting students to carry coverage that is above the limits imposed by the state. However, there are unique circumstances surrounding medical schools’ policies on liability coverage that would need to be examined further before determining whether this AMA policy should in fact be applied to medical schools.

## Conclusion

Medical liability coverage is a complex issue that affects medical providers at all levels of training, from medical students to practicing physicians. Currently, medical students are required to carry minimum levels of coverage due to mandates from states, hospitals, and their home institution. In some cases,

1 academic institutions are in fact requiring levels of coverage that are above those mandated by the state.  
2 However, the responsibility that a student should bear in the event of a malpractice suit has never been  
3 examined; similarly lacking is an examination into the appropriate levels of coverage for a student. This  
4 deficiency is problematic, as it has produced a patchwork of requirements on coverage for students that  
5 has proven to be a barrier in some cases when a student desires to pursue extramural electives. National  
6 bodies have provided little guidance as to how institutions should address the topic of medical liability  
7 coverage for students, further muddling the picture. Consideration of future medical liability coverage  
8 affects students' decisions on chosen specialty and region in which to practice, paralleling physicians'  
9 choices of specialties and regions that have friendlier medical liability environments. Any barriers to  
10 visiting externships that may dissuade students from exploring a potential specialty choice or from  
11 exploring a region in which they may eventually have chosen to practice will further this dilemma and  
12 should therefore be dealt with accordingly.

### 13 14 Recommendations

15  
16 Your MSS Governing Council recommends that the following be adopted in lieu of MSS Resolution 11-  
17 A-07 and that the remainder of this report be filed:

- 18  
19 1. That our AMA-MSS encourage the Association of American Medical Colleges to increase the  
20 utility of its Extramural Electives Compendium (EEC) by providing information regarding  
21 liability coverage requirements at all host institutions and by making this a searchable feature,  
22 and additionally that the AMA-MSS provide a link to the EEC on its Web site.  
23
- 24 2. That our AMA-MSS and AMA take into account the appropriate minimum levels of student  
25 liability coverage when examining the issue of student debt, particularly when in conversations  
26 with the administrations of various medical schools (New HOD Policy).  
27
- 28 3. That our AMA examine whether or not students have been found partially accountable in recent  
29 malpractice suits, as well as the appropriateness of the amounts of medical student liability  
30 coverage required by medical schools with respect to the current medical professional liability  
31 insurance market (Directive to Take Action).  
32
- 33 4. That our AMA examine the propriety of schools requiring their own and visiting students to carry  
34 levels of medical liability coverage in excess of the minimum amounts mandated for physicians  
35 by state law (Directive to Take Action).  
36

### 37 Acknowledgements

38  
39 The 2007-2008 MSS Committee on Medical Education is Chaired by Heidi Hullinger and Vice Chaired  
40 by Jaime Kearns. The Committee is additionally composed of Lindsay Caldwell, Elizabeth Burney  
41 Malinzak, Katherine Harvey, and Sean Tackett.  
42

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REPORT OF THE MEDICAL STUDENT SECTION  
GOVERNING COUNCIL

GC Report D  
(A-08)

Subject: Membership Dependent Voting Apportionment

Presented by: Rana Yehia, Chair

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

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1 Introduction  
2

3 At the 2007 MSS Annual Meeting, Recommendation 5 of RITForce Report A was referred to the  
4 Governing Council for decision:

- 5  
6 5. That the AMA-MSS Governing Council work with AMA-MSS and AMA Membership  
7 Department staff directly to:  
8 a. Establish a membership-dependent voting apportionment of representatives to the MSS  
9 Assembly.  
10 b. Determine a “bare minimum” standard for AMA-MSS membership at any campus wishing to  
11 be represented in the AMA-MSS Assembly, with report back to the AMA-MSS at A-08.  
12

13 Background  
14

15 MSS Regional Infrastructure Taskforce (RITForce) Report A-A-07 represented the culmination of more  
16 than three years of work by the MSS RITForce, which was charged with studying the best approach to  
17 improving and empowering the regional infrastructure. In completing its charge, RITForce gauged the  
18 opinions of MSS members through forums at national and Region meeting, online polls, and various other  
19 discussions. RITForce found that the MSS membership was first and foremost concerned with regional  
20 equality, in particular, proportional and fair representation in the MSS Assembly.  
21

22 Following long deliberations on the topic, RITForce ultimately determined that proportional  
23 representation in the MSS Assembly would ideally be based on the number of MSS members at each  
24 campus, rather than based simply on total campus population or on an even simpler one-vote-per-campus  
25 representation scheme. However, RITForce’s recommendation that the MSS establish membership-  
26 dependent voting apportionment was referred to the GC for decision after the Reference Committee heard  
27 testimony suggesting that such apportionment might not be feasible.  
28

29 Discussion  
30

31 The decision to establish membership-dependent voting apportionment hinges on the fundamental  
32 question of whether a representative to the MSS Assembly should represent an entire medical school  
33 student body or only the AMA members at that school. We believe that RITForce has already  
34 convincingly argued the latter and shown that the establishment of membership-dependent voting  
35 apportionment is vital to achieving fair and proportional representation. Consequently, our discussion  
36 here will address the feasibility, rather than the desirability, of membership-dependent voting  
37 apportionment in the MSS Assembly.

1 Unfortunately, at least two insurmountable logistical barriers make such voting apportionment infeasible  
2 at this time:

3  
4 First, reliable membership statistics broken down according to central and satellite campus status are not  
5 available. Medical student membership in the AMA (most of which is in the form of four-year  
6 memberships) is tracked according to the campus at which membership originates. Nearly all medical  
7 students who attend satellite campuses begin their medical school careers – and become AMA members –  
8 at central campuses before later transferring to satellite campuses. In many cases, students eventually  
9 transfer back to central campuses or even to other satellite campuses. Consequently, outside of  
10 conducting a labor-intensive and likely unreliable yearly census of all medical student members, it is  
11 impossible to track member movement between central and satellite campuses and therefore impossible to  
12 reliably determine membership breakdown between a central campus and its associated satellite  
13 campus(es) at any given time.

14  
15 Second, assuming that each campus must be apportioned at least one representative regardless of its  
16 membership size, membership-dependent voting apportionment would increase the overall size of the  
17 MSS Assembly beyond feasibility. The MSS Assembly is currently composed of approximately 210  
18 Delegates, the vast majority of whom represent central and satellite medical school campuses. In order to  
19 have any appreciable impact on proportionality of representation, the largest central campuses  
20 (membership approaching 1,000) would certainly have to be apportioned more representation than the  
21 mid-sized central campuses (membership approaching 500), which would have to be apportioned more  
22 representation than the large satellite campuses (membership approaching 100), which would have to be  
23 apportioned more representation than the smallest satellite campuses (membership under 20). Even if  
24 only one-half of all campuses each received one additional delegate (an ultra-conservative estimate of  
25 what it would take to achieve proportionality), the size of the MSS Assembly, including Alternates,  
26 would increase to more than 600. Given the limited space – the large meeting spaces at national meetings  
27 are reserved for the House of Delegates – and other resources available to the MSS, expansion of this  
28 magnitude or greater is neither logistically nor financially feasible.

### 29 30 Conclusion

31  
32 After careful consideration, your Governing Council has determined that, regardless of its perceived  
33 desirability, establishing membership-dependent voting apportionment in the MSS Assembly is not  
34 feasible at this time. Consequently, we have decided to not adopt Recommendation 5 of RITForce Report  
35 A-A-07.

REPORT OF THE MEDICAL STUDENT SECTION  
GOVERNING COUNCIL

GC Report E  
(A-08)

Subject: National Medical Student Organization Representation in the MSS Assembly

Presented by: Rana Yehia, Chair

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

---

1 Introduction

2  
3 At the 2007 MSS Interim Meeting, the recommendations of COLRP Report A - Biennial Review of  
4 National Medical Student Organizations Currently Represented in the MSS Assembly were referred to the  
5 Governing Council for decision:

- 6
- 7 1. That the MSS recommend to the AMA Board of Trustees that the following organizations no  
8 longer be represented as National Medical Student Organizations in the MSS Assembly: Student  
9 Aviation Management Association, American Association of Physicians of Indian Origin,  
10 American College of Legal Medicine, National Network of Latin American Medical Students,  
11 Student National Medical Association.
  - 12 2. That, per MSS Internal Operating Procedure VIII. C, 5., the MSS confer official observer status  
13 on the American Association of Physicians of Indian Origin, the American College of Legal  
14 Medicine, the National Network of Latin American Medical Students, the Student National  
15 Medical Association, and the American Physician Scientists Association.
  - 16 3. That the MSS consider amending AMA Bylaw 7.3341 (b) to read: “The organization must be  
17 composed ~~solely~~ primarily of medical students enrolled in a Liaison Committee on Medical  
18 Education or American Osteopathic Association accredited program.”
  - 19 4. That the MSS consider amending the AMA Bylaws to permit voting representation in the MSS  
20 Assembly for the Association of American Medical Colleges – Organization of Student  
21 Representatives and its equivalent osteopathic medical student organization.
  - 22 5. That the AMA-MSS Governing Council reinforce the biennial review process for NMSOs as  
23 outlined in MSS Internal Operating Procedure VIII. C. 4.
- 24

25 The goal of this report is to justify and recommend AMA Bylaw and MSS Internal Operating Procedure  
26 (IOP) amendments to ensure that the important voices of National Medical Student Organizations  
27 (NMSOs) continue to be heard in the MSS Assembly.

28  
29 The MSS Governing Council asked the 2007-2008 MSS Committee Long Range Planning to research  
30 and complete this report and fully endorses the Committee’s work.

31  
32 Background

33  
34 National Medical Student Organizations (NMSOs) are granted representation in the MSS Assembly  
35 according to rules set forth by the AMA Bylaws and the MSS Internal Operating Procedures (IOPs).  
36 Specifically, any NMSO wishing to be represented in the MSS Assembly must meet the following  
37 eligibility criteria:

- 1 a. The organization must be national in scope.
- 2 b. The organization must be composed solely of medical students enrolled in a Liaison Committee
- 3 on Medical Education or American Osteopathic Association accredited program.
- 4 c. Membership in the organization must be available to all medical students, without discrimination.
- 5 d. The purposes and objectives of the organization must be consistent with the AMA's purposes and
- 6 objectives.
- 7 e. The organization's code of medical ethics must be consistent with the AMA's Principles of
- 8 Medical Ethics.
- 9

10 If an organization meets these eligibility criteria, the MSS Governing Council (GC) may submit a  
11 recommendation to the AMA Board of Trustees (BOT) that the NMSO be granted representation in the  
12 MSS Assembly. After approval by the BOT, an NMSO must undergo biennial review to ensure that it  
13 continues to meet these eligibility criteria. If an NMSO previously granted representation is found to not  
14 qualify under the above eligibility criteria, the MSS GC may submit a recommendation to the BOT that  
15 the NMSO's representation in the Assembly be revoked.

16  
17 In reviewing the recent application of the American Physician Scientists Association for representation in  
18 the MSS Assembly, it came to the attention of the MSS that some NMSOs currently represented in the  
19 MSS Assembly include non-medical student members in their memberships (e.g. pre-medical  
20 undergraduates, residents/fellows, etc.). COLRP Report A-I-07 reviewed the eligibility of NMSOs  
21 currently represented in the MSS Assembly and determined that a number of them were no longer eligible  
22 for representation under the current criteria.

23  
24 Most of the NMSOs found to be ineligible meet all eligibility criteria except the requirement that an  
25 NMSO be composed solely of medical students (Appendix 1). COLRP Report A-I-07 recommended that  
26 these NMSOs be stripped of their voting representation in the MSS Assembly and granted "official  
27 observer" status until such time that the Bylaws and IOPs could be amended to allow for representation of  
28 NMSOs composed primarily, as opposed to solely, of medical students. The MSS Assembly was split  
29 over whether and how the Bylaws and IOPs should be enforced, and the recommendations of COLRP  
30 Report A-I-07 were ultimately referred to the GC for decision.

31  
32 We believe that granting official observer status in the MSS Assembly to those organizations that do not  
33 meet each criterion for full voting-rights is not an adequate solution. Official observers reserve the right  
34 to speak and debate on the floor of the Assembly upon invitation from the Speaker, but do not have the  
35 right to introduce business, introduce an amendment, make a motion, or vote. Although in principle,  
36 granting official observer status enables these organizations to provide their voice and their perspective,  
37 in reality this is not the case. Traveling to a national meeting entails considerable expense. Just as state  
38 delegations and individual schools are more inclined to fund their students to attend our national  
39 meetings, parent organizations in many cases fund students to attend a national meeting because they  
40 have a vote in our Assembly.

41  
42 Consequently, instead of immediately revoking the representation of ineligible NMSOs and conferring  
43 non-voting official observer status on them, we have decided to delay enforcement of the AMA Bylaws  
44 and MSS IOPs until the necessary Bylaw and IOP amendments can be made. We have worked with the  
45 AMA Council on Constitution and Bylaws (CC&B) to expedite the process of proposing Bylaws changes  
46 that will prevent the revocation of MSS Assembly representation for NMSOs that meet all current  
47 eligibility criteria except for the requirement that an NMSO be composed solely of medical students.

1 Discussion

2  
3 The MSS Assembly was established to ensure that the decisions made by the MSS reflect the will of  
4 student members and to ensure that students receive fair representation. Our decisions as an organization  
5 should be made with a wide breadth of perspective, consensus, and academic discussion. We assemble  
6 and vote on policies as our best means of reflecting this collective thought within our decisions.  
7 Representation of NMSOs in the MSS Assembly provides a valuable opportunity for the MSS to hear  
8 underrepresented opinions, to foster contacts with organizations whose missions resemble our own, and to  
9 potentially improve the diversity of our membership. In order to ensure the continued representation of  
10 NMSOs within the MSS Assembly, we propose the following amendments to the AMA Bylaws and MSS  
11 IOPs:

12  
13 *Establishing representation for NMSOs that are composed primarily, as opposed to solely, of medical*  
14 *students*

15 The AMA Bylaws and MSS IOPs currently restrict representation in the MSS Assembly to NMSOs that  
16 are composed solely of medical students enrolled in LCME or AOA accredited U.S. medical schools  
17 (7.3341 Criteria for Eligibility, see Appendix 2 for relevant Bylaws and IOPs). The majority of the  
18 NMSOs deemed ineligible for representation by COLRP Report A-I-07 were deemed so only because  
19 they allow non-medical student members (e.g. residents, premedical undergraduates, etc.). NMSOs in  
20 this category include the American Association of Physicians of Indian Origin (AAPI), the American  
21 College of Legal Medicine (ACLM), the National Network of Latin American Medical Students  
22 (NNLAMS), and the Student National Medical Association (SNMA). Within some of these organizations  
23 (notably NNLAMS and SNMA), full membership (including voting privileges) is available only to  
24 medical students. Premedical students and others do not have a vote in the organizations' deliberations.  
25 Thus, even if these organizations were to be represented in the MSS Assembly, premedical students and  
26 others would be far-removed from having any influence on the decisions of the MSS.

27  
28 Recognizing that these NMSOs are geared toward students, primarily represent student interests, and  
29 provide a valuable medical student perspective within the MSS Assembly, we recommend that the AMA  
30 Bylaws and MSS IOPs be amended to permit representation for student organizations whose core  
31 memberships are composed of medical students from LCME or AOA accredited schools, regardless of  
32 whether the organizations allow allied non-medical student membership. The AMA-MSS must determine  
33 where the line lies between an organization having a sufficient number or proportion of medical students  
34 to appropriately share a student perspective and an organization in which the medical student population  
35 is so diffuse that the organization's perspective does not truly represent a medical student perspective.

36  
37 *Establishing automatic representation for all student groups whose parent organizations are seated in the*  
38 *HOD*

39 The current AMA Bylaws and MSS IOPs allow a student group to circumvent the NMSO application and  
40 biennial review processes and gain automatic representation in the MSS Assembly if its parent  
41 organization is a national medical specialty society seated in the HOD (B-7.333 National Medical  
42 Specialty Societies). For example, the student sections of the American Academy of Family Physicians  
43 (AAFP) and the American College of Emergency Physicians (ACEP) are granted automatic  
44 representation in the MSS Assembly because AAFP and ACEP are seated in the HOD as national medical  
45 specialty societies.

46  
47 Unfortunately, due to what we believe to be an oversight in the Bylaws, this exemption does not currently  
48 apply to student groups whose parent organizations are represented in the HOD in any capacity other than  
49 as national medical specialty societies. For example, the National Medical Association (NMA) and the  
50 American Association of Physicians of Indian Origin (AAPI) are seated in the HOD, but not as specialty  
51 societies. Consequently, these organizations' affiliated student groups (SNMA and the student section of  
52 AAPI) must pursue representation in the MSS Assembly as NMSOs and must bear all the attendant  
53 difficulties associated with gaining and maintaining NMSO status.

1 The NMSO application and biennial review processes were established to ensure that student  
2 organizations granted a voice in our Assembly truly represent the interests of medical students and not the  
3 interests of constituencies outside the realm of organized medicine (e.g. premedical students, allied health  
4 professions students, etc.). We believe that the HOD vetting process for physician groups wishing to be  
5 seated in the HOD (the Specialty and Service Society caucus) is sufficiently stringent to ensure that  
6 student affiliates of parent organizations already granted representation in the HOD truly represent the  
7 viewpoint of medical students and of organized medicine. Consequently, we recommend that the AMA  
8 Bylaws and MSS IOPs be amended to establish automatic representation for all medical student groups  
9 affiliated with parent organizations seated in the HOD.

10  
11 *Establishing representation for student organizations that play an integral role in the affairs of medical*  
12 *education*

13 Under the current NMSO eligibility criteria, important student organizations that represent the specific,  
14 medical education-related interests of allopathic and osteopathic medical students are denied  
15 representation in the MSS Assembly. Specifically, the Association of American Medical Colleges –  
16 Organization of Student Representatives (AAMC-OSR) can not be granted representation as an NMSO  
17 because its membership is not available to all medical students. (AAMC-OSR membership is available  
18 only to allopathic medical student leaders; other allopathic students and all osteopathic students are  
19 excluded.) The American Association of Colleges of Osteopathic Medicine – Council of Osteopathic  
20 Student Government Presidents (AACOM-COSGP) is likewise ineligible for representation as an NMSO.  
21 Recognizing the value that these specific organizations add to the MSS Assembly, we recommend that  
22 the AMA Bylaws and MSS IOPs be amended to establish representation in the MSS Assembly for  
23 AAMC-OSR and for AACOM-COSGP.

24  
25 Conclusion

26  
27 In order to broaden the perspective of its Assembly to be more representative of its membership, it is  
28 within the best interests of the AMA-MSS to immediately pursue the AMA Bylaw and MSS IOP  
29 amendments outlined above. The continued presence of NMSOs in our Assembly will bring medical  
30 students with this depth of perspective to our Assembly and will maintain an environment of  
31 inclusiveness and discussion.

32  
33 Recommendations

34  
35 Your Governing Council has decided to not adopt the recommendations of COLRP Report A-I-07.  
36 Instead, we recommend that the following be adopted and that the remainder of this report be filed:

- 37  
38 1. That the following organizations maintain their voting representation within the AMA-MSS  
39 Assembly: American Association of Physicians of Indian Origin, American College of Legal  
40 Medicine, Asian Pacific American Medical Student Association, Military Medical Student  
41 Association, National Network of Latin American Medical Students, and Student National  
42 Medical Association.
- 43  
44 2. That the eligibility criteria for National Medical Student Organizations (NMSOs) as set forth in  
45 the AMA Bylaws and the MSS IOPs be amended to allow representation to the MSS Business  
46 Meeting for NMSOs whose memberships are composed primarily, as opposed to solely, of  
47 medical students. The MSS Governing Council will make a recommendation to the AMA Board  
48 of Trustees as to whether a prospective NMSO is composed “primarily” of medical students.
- 49  
50 3. That the AMA Bylaws and MSS IOPs be amended to establish automatic representation to the  
51 MSS Business Meeting for every student group affiliated with a parent organization seated in the  
52 AMA House of Delegates.

1 4. That the AMA Bylaws and MSS IOPs be amended to establish representation to the MSS  
2 Business Meeting for the Association of American Medical Colleges – Organization of Student  
3 Representatives and for the American Association of Colleges of Osteopathic Medicine – Council  
4 of Osteopathic Student Government Presidents.

5  
6 5. That the recommendations of this report be forwarded to the AMA House of Delegates at A-08.  
7

8 Acknowledgements  
9

10 The MSS Committee on Long-Range Planning is Chaired by Justin Mahida and Vice-Chaired by  
11 Kimberly Indovina. The members of the Committee include Christopher Alvarez-Breckinridge, Adam  
12 Currier, Linda Dultz, Chin Ho, Varun Kumar, Richard Myers, Jeanine Spielberger, Todd Theman, and  
13 Alik Widge.  
14

15 The MSS Minority Issues Committee is Chaired by Enrico Castillo. The members of the Committee  
16 include Cassandra Bradby, Kamel Brakta, Felicity Kelly, Kawan Swain, and Justin Taylor.  
17

18 We would like to thank Travis Gayles, MSS Representative to the AMA Minority Affairs Consortium;  
19 Elizabeth Homan, MSS Representative on behalf of the National Network of Latin American  
20 Medical Students representatives; and Edward Gometz, an MSS member from the University of Chicago.

### Appendix 1: Individual Analysis of NMSOs

There are currently eight NMSOs represented in the MSS Assembly:

- Asian Pacific American Medical Student Association (APAMSA)
- Association of American Medical Colleges Organization of Student Representatives (AAMC-OSR)
- Military Medical Student Association (MMSA)
- American Association of Physicians of Indian Origin (AAPI)
- American College of Legal Medicine (ACLM)
- National Network of Latin American Medical Students (NNLAMS)
- Student Aviation Management Association (SAMA)
- Student National Medical Association (SNMA)

Of the eight current NMSOs, two are in accordance with MSS IOPs and AMA Bylaws: The Asian Pacific American Medical Student Association (APAMSA) and the Military Medical Student Association (MMSA).

Of the remaining six current NMSOs, four were found to be national in scope, have purposes roughly aligned with the objectives of the AMA-MSS, and have membership available to all medical students. Codes of medical ethics could not be found for these organizations and were not reviewed, but these organizations did state goals and ideals that did appear to be in accordance with AMA Principles of Ethics. We did, however, find multiple violations of the criterion that members be comprised solely of medical students in LCME or AOA accredited schools, and one case where an NMSO met only the requirement for non-discrimination in membership availability. The following is a discussion of each case.

#### Asian Pacific American Medical Student Association (APAMSA)

- a. APAMSA is a national organization.
- b. APAMSA is composed of medical students from U.S. medical schools.
- c. Membership is open to any medical student.
- d. Mission includes “bring[ing] together Asians and others interested in the health issues that affect Asians,” “promoting the health and well-being of the Asian community,” “helping all health care workers...understand how to care for the Asian patient in a culturally sensitive manner,” and providing a forum for medical students to develop professionally.
- e. No code of medical ethics could be obtained, but APAMSA’s goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://www.apamsa.org/home/membership/>

[http://www.apamsa.org/home/about\\_us/mission.php](http://www.apamsa.org/home/about_us/mission.php)

#### Association of American Medical Colleges Organization of Student Representatives (AAMC-OSR)

- a. AAMC-OSR is a national organization.
- b. “OSR representatives include one primary and three alternate institutional representatives from each of the 126 [LCME-accredited] U.S. allopathic medical schools. OSR associate representatives are medical students who are enrolled in Canadian medical schools.”
- c. Membership is available only to medical students enrolled in LCME-accredited (allopathic) medical schools. Furthermore, membership is restricted to one primary and three alternate representatives per medical school.
- d. The OSR “provides all United States allopathic medical students with voting representation to the nation's largest association dedicated solely to the advancement of academic medicine. The OSR provides medical students with an active role in achieving AAMC's mission to improve the nation's health through the advancement of academic medicine.”
- e. No code of medical ethics could be obtained, but AAMC-OSR’s goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://www.aamc.org/members/osr/membership/start.htm>

<http://www.aamc.org/members/osr/about/mission.htm>

#### Military Medical Student Association (MMSA)

- a. MMSA is a national organization.
- b. Members include students from the Health Professions Scholarship Program, the Uniformed Services University of the Health Sciences, and medical students considering a career in military medicine.
- c. Membership is open to all medical students without discrimination.

- d. The MMSA's main goals include developing lines of communication among military medical students across the country, serving as an information source for those medical students, and promoting unity and *esprit de corps* among future military medical officers.
- e. No code of medical ethics could be obtained, but MMSA's goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://www.militarymedicine.org/home.html>

#### **American Association of Physicians of Indian Origin (AAPI)**

- a. AAPI is a national organization.
- b. AAPI represents physicians and dentists of Indian origin, but its bylaws allow for non-physician membership. Associate Members may include "persons engaged in professions or career in the human sciences other than medicine and dentistry," and Sponsor Members include "industrial partners of AAPI who sponsor programs and activities of AAPI and satisfy criteria as set by the Executive Committee." Furthermore, the AAPI Governing Body reserves the right to create other special categories of membership. A Medical Student/Resident Section exists.
- c. Membership is open to any medical student.
- d. AAPI's mission is "to facilitate and enable Indian American Physicians. To excel in patient care, teaching and research and to pursue their aspirations in professional and community affairs." Goals and values include statements surrounding excellence in patient care, professionalism, ethics, and education.
- e. No code of medical ethics could be obtained, but AAPI's goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://www.aapiusa.org/about/viewlaws.htm>

<http://www.aapiusa.org/about/aboutus.htm>

#### **American College of Legal Medicine (ACLM)**

- a. ACLM is a national organization.
- b. This organization includes members other than those enrolled in LCME or AOA accredited medical schools. They accept physicians, dentists, lawyers, health science professionals, other persons with medical-legal expertise, medical students, dental students and law students.
- c. Membership is open to any student in an accredited medical school.
- d. The ACLM "educates and assists healthcare and legal professionals, advances the administration of justice, influences health policy and improves healthcare, promotes research and scholarship, and facilitates peer group interaction."
- e. No code of medical ethics could be obtained, but ACLM's goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://www.aclm.org/about/bylaws.aspx#1>

<https://www.aclm.org/Default.aspx>

#### **National Network of Latin American Medical Students (NNLAMS)**

- a. NNLAMS is a national organization.
- b. This organization has three tiers of membership. Full membership is granted to "medical and allied health professional students," Affiliate membership to "residents, physicians, and other allied health professionals," and Provisional membership to "pre-medical and allied pre-professional students." Provisional members may sit on committees but cannot serve on the Executive Board lead committees, or lead task forces.
- c. Membership is open to any medical student at an accredited school in the U.S. or Puerto Rico.
- d. The NNLAMS mission statement calls for the unification of Latino medical students, promoting recruitment/retention of Latino students, education surrounding Latino health issues, advocacy, leadership, and volunteerism within the Latino community.
- e. No code of medical ethics could be obtained, but NNLAMS's goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://www.nnlams.com/constitution.htm>

<http://www.nnlams.com/mission.html>

#### **Student Aviation Management Association (SAMA)**

- a. This organization was founded at the University of North Dakota to represent Airport Administration majors and is an academic chapter of the American Association of Airport Executives. While they may accept members from other schools (this is not clear), in practice they appear limited to one university; therefore, they are not national in scope.

- b. SAMA is open to students of “all majors;” its membership is certainly not limited to medical students.
- c. SAMA is open to all University of North Dakota students, without discrimination based on field of study or any other criteria.
- d. SAMA’s purpose is not directly related to medicine. Its primary goals include “to promote aviation professionalism and camaraderie at the collegiate level, and to develop scholastic relationships with the entire University of North Dakota’s student population.”
- e. SAMA has no stated code of medical ethics and no stated goals related to medical ethics. However, in discussion with its student members, SAMA’s goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://sama.aero.und.edu/index.htm>

**Student National Medical Association**

- a. SNMA is a national organization.
- b. This organization utilizes a tiered membership structure. Active membership is restricted to matriculated students at “allopathic and osteopathic medical programs” and “represents the core of the SNMA membership body.” Associate membership is given to pre-medical students and “students involved in health related studies.” There are also membership categories for physicians, allied professionals (community service , teachers, government officials, et al), and corporations.
- c. SNMA is open to all medical students without discrimination.
- d. “SNMA is committed to supporting current and future underrepresented minority medical students, addressing the needs of underserved communities, and increasing the number of clinically excellent, culturally competent and socially conscious physicians.” Its stated goals include recruitment and retention of minority medical students, community service, education, and health policy and advocacy.
- e. No code of medical ethics could be obtained, but SNMA’s goals appear to be compatible with the AMA Principles of Medical Ethics.

<http://www.snma.org/membership.php>

<http://www.snma.org/about-our-mission.php>

The following table summarizes these findings:

Organization	a. National in scope	b. Solely LCME/AOA med students	c. Open to all med students w/o discrimination	d. Consistent with AMA purposes/objectives	e. Code of medical ethics consistent with AMA
APAMSA	yes	yes	yes	yes	Likely
AAMC-OSR	yes	yes	<b>no</b>	yes	Likely
MMSA	yes	yes	yes	yes	Likely
AAPI	yes	<b>no</b>	yes	yes	Likely
ACLM	yes	<b>no</b>	yes	yes	Likely
NNLAMS	yes	<b>no</b>	yes	yes	Likely
SAMA	<b>no</b>	<b>no</b>	yes	<b>no</b>	Likely
SNMA	yes	<b>no</b>	yes	yes	Likely

**Appendix 2: Relevant AMA and MSS Policy**

**From AMA Bylaw 7.30 Medical Student Section**

**7.333 National Medical Specialty Societies.** Each national medical specialty society granted representation in the House of Delegates that has established a medical student component is entitled to one representative and one alternate representative selected by the medical student members of the specialty society. The Governing Council shall adopt uniform rules and criteria to determine if a national medical specialty society has established a medical student membership component so as to qualify for representation at the Business Meeting. The procedure by which the medical student representative from the specialty society is selected must meet the requirements established by the Governing Council.

**7.334 National Medical Student Organizations.** National medical student organizations that have been granted representation in the Medical Student Section Business Meeting may select one representative and one alternate representative.

**7.3341 Criteria for Eligibility.** National medical student organizations that meet the following criteria may be considered for representation in the Medical Student Section Business Meeting:

a. The organization must be national in scope. b. The organization must be composed solely of medical students enrolled in a Liaison Committee on Medical Education or American Osteopathic Association accredited program. c. Membership in the organization must be available to all medical students, without discrimination. d. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives. e. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

**7.3342 Procedure.** The Medical Student Section shall adopt appropriate rules for the application, acceptance and retention of national medical student organizations. Recommendations for acceptance and discontinuance shall be subject to the approval of the Board of Trustees.

**7.3343 Rights and Responsibilities.** The medical student representative of each national medical student organization granted representation in the Business Meeting shall have full voting rights, including the right to vote in any elections at the conclusion of a two-year probationary period with regular attendance. The representatives shall not be eligible for election to any office in the Medical Student Section.

7.334 National Medical Student Organizations. National medical student organizations that have been granted representation in the Medical Student Section Business Meeting may select one representative and one alternate representative.

**MSS Internal Operating Procedure VIII. C. 4. National Medical Student Organizations**

4. National Medical Student Organizations.

a. The following criteria have been developed for national medical student organizations to qualify for representation in the MSS Assembly, pursuant to AMA Bylaw 7.3341. A national medical student organization must:

- i. Be national in scope.
- ii. Be composed solely of medical students enrolled in an LCME- or AOA-accredited educational program.
- iii. Membership in the organization must be available to all medical students, without discrimination.
- iv. The purposes and objectives of the organization must be consistent with the AMA's purposes and objectives.
- v. The organization's code of medical ethics must be consistent with the AMA's Principles of Medical Ethics.

b. Interested national medical student organizations should submit a written application containing sufficient information to establish that the organization meets the above criteria. The applications must also include the following:

- i. The organization's charter, constitution, bylaws, and code of medical ethics.

- ii. A list of the sources of the organization's financial support, other than the dues of its medical student members.
  - iii. A list or description of all of the organization's affiliations.
  - iv. Such additional information as may be requested.
- c. The MSS Governing Council shall review the application. If it recommends that the organization be granted representation in the MSS Assembly Meeting, the recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the organization may be represented in the MSS Assembly Meeting.
  - d. Each national medical student organization represented in the MSS Assembly will be required to reconfirm biennially that it continues to meet the criteria for eligibility by submitting such information and documentation as may be required by the MSS Governing Council.
  - e. Organizations will be notified by the Governing Council of the time of their review and will be asked to submit appropriate documentation.
  - f. Failure to participate in the biennial review process or to meet the established criteria will be reported to the MSS Governing Council for action.
  - g. The Governing Council may recommend discontinuance of the representation by a national medical student organization on the basis that the organization fails to meet the above criteria, has failed to maintain its responsibilities outlined in these Internal Operating Procedures, or has failed to attend the MSS Assembly Meeting. The recommendation shall be submitted to the AMA Board of Trustees for review. If approved by the AMA Board of Trustees, the representation of the national medical student organization in the MSS Assembly Meeting shall be discontinued..
  - h. The medical student representative of each national medical student organization granted representation at the Assembly Meeting shall:
    - i. Have full voting rights including the right to vote in any elections at the conclusion of a two-year probationary period with regular attendance.
    - ii. Not be eligible for election to any office in the MSS.
    - iii. Be able to present its policies and opinions in the Assembly Meeting.
    - iv. Report on the actions of the MSS to the national medical student organization.
    - v. Cooperate in enhancing the MSS membership.
  - i. All representatives to the MSS Assembly Meeting must be medical student members of the AMA and shall be properly certified to the MSS Governing Council in accordance with rules established by the Governing Council.

#### **MSS Internal Operating Procedure VIII. C. 5. Official Observer**

5. Official Observer.
  - a. National student organizations may apply to the MSS Governing Council for official observer status in the MSS Assembly. Applicants and official observers must demonstrate compliance with guidelines for official observers adopted by the MSS Assembly, and the Governing Council shall make a recommendation to the MSS Assembly concerning the application. The MSS Assembly will make the final determination on the conferring or continuation of official observer status.
  - b. Organizations with official observer status are invited to send one representative to observe the actions of the Assembly at all meetings of the MSS Assembly. Official observers have the right to speak and debate on the floor of the Assembly upon invitation from the Speaker. Official observers do not have the right to introduce business, introduce an amendment, make a motion, or vote.

REPORT OF THE MEDICAL STUDENT SECTION  
GOVERNING COUNCIL

GC Report F  
(A-08)

Subject: Antimicrobial Resistance: Dearth of Novel Antibiotics

Presented by: Rana Yehia, Chair

Referred to: MSS Reference Committee  
(Despina Siolas, Chair)

---

1 Introduction  
2

3 At the 2007 MSS Interim Meeting, MSS Resolution 18 – Dearth of Novel Antibiotics was referred as  
4 amended to the MSS Governing Council for report back at A-08:  
5

6       RESOLVED, That our AMA endorse legislation or lobby for legislation that will grant  
7       companies tax incentives for pursuing antibiotic research. (Any expenditure towards the  
8       development of a new class of antibiotic would not be taxed.)  
9

10 The MSS Governing Council enlisted the aid of the 2007-2008 MSS Committee on Public Health to  
11 research and complete this report and fully endorses the Committee’s work.  
12

13 Background  
14

15 After decades of remarkable progress in the ability of medicine to treat microbial infections, the last  
16 twenty-five years have seen a rapid increase in antimicrobial-resistant pathogens. According to the  
17 Institute of Medicine’s 1998 paper, *Antimicrobial Resistance: Issues and Options*, antibiotic resistance  
18 and the dearth of antibiotic research and development (R&D) are increasing threats to public health in the  
19 United States<sup>1,2</sup>.  
20

21 Currently, 70 percent of bacteria that cause infections in hospitals are resistant to at least one class of  
22 antibiotics. Although the vast majority of bacterial infections can be treated with existing antibiotics,  
23 bacterial resistance to all known antimicrobials has been reported<sup>3</sup>. In 2005, nearly 400,000 cases of  
24 methicillin-resistant *Staphylococcus aureus* (MRSA) infections were reported, a 300 percent increase  
25 since 2000<sup>4</sup>. By increasing the length of stay in hospitals and requiring higher intensity resources, these  
26 infections increase health care expenditures by approximately \$5 billion each year<sup>5</sup>. One study estimates  
27 that antibiotic-resistant gram-negative infections increased hospital costs by \$11,000 per patient<sup>6</sup>.  
28 However, the present impact of antibiotic-resistant infections (ARIs) is small compared to the potential  
29 costs that can be expected if the public health community, health care providers, and patients remain  
30 passive. As life expectancy increases, treatments become more intense, patient complexity increases, and  
31 the number of people living with immune deficiencies increases, the problem of antimicrobial-resistant  
32 pathogens will become more severe and urgent<sup>7-10</sup>.  
33

34 This report will discuss potential solutions to the problem of antimicrobial-resistant pathogens. To be  
35 effective, these solutions will need to be multi-faceted and promote the development of antibiotics as well

1 as involve public health initiatives to prevent the development and spread of resistant pathogens\*. The  
2 first part of this report will discuss mechanisms for stimulating pharmaceutical R&D of drugs targeted at  
3 antibiotic-resistant pathogens. The second part will discuss public health initiatives targeted at preventing  
4 the development and spread of resistant pathogens by using provider and patient education, regulating the  
5 use of antibiotics, and improving current public health policies as they pertain to the sharing of  
6 information about resistance and the agricultural use of antibiotics.

### 7 8 Dearth of Novel Antibiotics

9  
10 The existence of pathogens resistant to all current antibiotics suggests that novel antibiotics need to be  
11 developed to treat infections with these organisms<sup>11</sup>. Unfortunately, even as the number of pathogens  
12 resistant to existing antibiotics increases, the number of antibiotics being developed has decreased in both  
13 America and Europe<sup>12</sup>. The decline in antibiotic development follows a general trend in fewer approvals  
14 for new molecular entities (NMEs), and antibiotics have been particularly lacking. In 2002, 89 new drugs  
15 were approved in the United States, but none of these was an antibiotic<sup>13</sup>. In order to be prepared for an  
16 epidemic of antibiotic resistant infections, the development of novel antibiotics must be continuous; while  
17 pathogens can develop resistance sporadically, developing a new antibiotic can take well over a decade<sup>14</sup>.  
18 Reports of novel antibiotics entering the early stages of clinical trials hold potential, but cannot be relied  
19 on as the solution until a number of these antibiotics are approved<sup>15-17</sup>.

20  
21 The dearth of new antibiotics can be attributed to a number of factors. For one, there has been an increase  
22 in concern about the safety of NMEs by federal regulators, “patient” watch groups, and litigators.  
23 Secondly, the cost of R&D has increased dramatically over the last two decades. Clinical trials are now  
24 more complex, require larger numbers of subjects (which can be difficult to obtain), require longer  
25 periods of follow-up on patients (because pharmaceuticals are now targeted at chronic diseases), and  
26 require increasingly sophisticated technology. In addition, the cost of clinical trials has increased in  
27 response to increased demand for pre-market testing by payers concerned with cost-effectiveness<sup>18</sup>.  
28 These factors have increased the cost of new drug development to approximately \$802 million, as  
29 compared to just \$313 million in 1991<sup>19</sup>.

30  
31 In addition to the rising costs of R&D making it more important for pharmaceutical firms’ NMEs to be  
32 more profitable, other barriers exist that have impeded the development of novel antibiotics. Analysts  
33 have cited scientific barriers, pharmaceutical firms’ preference for drugs that have a higher expected  
34 profit, uncertainty regarding regulatory standards of New Drug Evaluation (NDE) approvals, and certain  
35 intellectual property protections as being almost as important as the cost increases in slowing antibiotic  
36 development<sup>20,21</sup>.

### 37 38 Strategies to Increase Pharmaceutical Development

39  
40 The low number of new antibiotics suggests that current market incentives are insufficient and that  
41 artificial incentives may be necessary to stimulate pharmaceutical R&D. There are some notable  
42 differences between pharmaceutical R&D and that of other industries that help explain the reasons why  
43 subsidizing the pharmaceutical industry will improve the general good. These differences stem from the  
44 unusually long time lag between drug development and its market introduction, the issue that adverse  
45 drug events (ADEs) may not occur until many years following a drug’s introduction, and the high cost,  
46 uncertainty, and risk that accompany pharmaceutical R&D.

---

\* Although bacteria compose a significant majority of organisms resistant to pharmaceuticals, the term “pathogen” will be used to discuss all organisms that are resistant to pharmaceuticals because helminthes and viruses can also develop resistance.

1 In addition, drugs targeted towards antimicrobial-resistant pathogens pose their own set of research  
2 barriers. First, antibiotic-resistant organisms develop spontaneously. Because of their unpredictable  
3 nature, there is no basis on which to begin drug development. This void in scientific knowledge requires  
4 both basic research and applied research to be done before a drug can be brought to market. These new  
5 strains also could pose serious health concerns by rapidly infecting a large number of patients. Therefore,  
6 new drugs must be developed quickly. However, this might lead to conflicting incentives for  
7 pharmaceutical firms. A quickly developed drug that is effective and safe is certainly optimal from a  
8 public health point of view, but a new drug that reduces the incidence and prevalence of an infection also  
9 reduces the need for the drug, and hence the monetary returns on the drug. Any program aimed at  
10 increasing pharmaceutical R&D will need to address this issue.

11  
12 Further, drugs that treat antibiotic-resistant infections may be viewed as “public goods” in much the same  
13 way that a vaccine is a public good. Because of the nature of communicable diseases, people may benefit  
14 from the development of antibiotics that treat ARIs even if they never use these medications. However,  
15 because the development costs of a new drug are high, these medications may not be developed unless the  
16 costs are spread over the tax base of all those who potentially benefit.

### 17 18 **Push incentives**

19 In order to increase the development of novel antibiotics, both “push” and “pull” incentives can be  
20 implemented. Push incentives are those that lower the expected cost of developing a new drug, whereas  
21 pull incentives are those that increase the expected return on the new drug. Push incentives such as tax  
22 credits, research grants, “Fast-Track” FDA approval, and expert guidance from the FDA have been used  
23 in legislation such as the Orphan Drug Act (ODA), the United States’ Tax Reform Act of 1986 (USTRA),  
24 and the Economic Recovery and Tax Act of 1981 (ERTA). Examples of pull strategies include advanced  
25 market agreements (AMAs), patent extensions, market exclusivity, and the ability to transfer patents  
26 between different drugs. These pull incentives have been used to increase vaccine production and to  
27 procure drugs for developing countries, as well as to stimulate domestic R&D.

### 28 29 *Tax incentives*

30 Push incentives have been included in legislation for nearly 30 years. A common feature of much of this  
31 legislation has been tax credits. The ODA provided a 50 percent tax credit for drugs that treat “orphan”  
32 diseases, whereas ERTA and USTRA provided a 25 percent tax credit for all R&D. Canada was one of  
33 the first countries to use tax credits to stimulate R&D, but such tax credits are now ubiquitous throughout  
34 Europe and among other members of the Organization for Economic Cooperation and Development  
35 (OECD).

36  
37 Initial research from the 1980s on the effects of the tax credits on R&D was not encouraging<sup>22</sup>. However,  
38 more recent studies have shown that these incentives have proven to be cost-effective. It is now thought  
39 that a 1.6 percent increase in pharmaceutical R&D is attributable to USTRA<sup>23</sup>. The international  
40 literature also supports this conclusion and suggests that R&D tax credits that lower the cost of R&D by  
41 10 percent will increase R&D expenditures by 1 percent in the short run and by 10 percent in the long  
42 run, making them more cost-effective compared to other government subsidy programs. In particular, tax  
43 credits included in the ODA are believed to be a major contributor in the development of more than 200  
44 drugs to treat orphan diseases since 1983, compared to fewer than 10 drugs developed during the previous  
45 decade<sup>24</sup>. Further supporting the evidence of the effectiveness of tax credits is success in industries other  
46 than pharmaceuticals. The evidence, therefore, is overwhelming in favor of the cost-effectiveness of tax  
47 credits in stimulating R&D<sup>25,26</sup>.

48  
49 The less impressive stimulatory effects of tax credits found in initial studies can be attributed to the lag  
50 time from implementation to observable effects. Because of the lengthy approval process, the impact of  
51 the study will not be visible until the drugs stimulated by this incentive are approved, which can take as  
52 long as 10 to 12 years. Unfortunately, the delay in the effects of a tax credits may be problematic for

1 stimulating development of new antibiotics. Antibiotics targeted at newly discovered antibiotic-resistant  
2 pathogens should be developed quickly in order to be most effective and to prevent the spread of these  
3 pathogens. Unfortunately, a lag of 10 years may simply be too long to be useful for stimulating antibiotic  
4 research if time-to-market is an important component of the benefit of the new antibiotic.

#### 5 6 *Grants*

7 Similar to tax credits, research grants also can be used to stimulate R&D. Historically, grants awarded to  
8 private firms have been small monetary amounts that have been restricted to the earliest stages of drug  
9 development. However, larger grants are commonly awarded to fund basic research at academic centers  
10 and government-sponsored institutions. And it is these grants to universities, the National Institutes of  
11 Health (NIH), or similar bodies that can provide the greatest returns. Although research grants have been  
12 fundamental in generating new drugs, grants provided specifically to pharmaceutical firms to develop  
13 specific drugs have been less successful.

14  
15 The effects of grants aimed at the development of a single class of drugs or vaccines are not well  
16 documented, but the consensus is that they should be restricted for basic research, rather than later stages  
17 of development. One illustrative example is the use of grants by the United States Agency for  
18 International Development (USAID) to fund research of a malaria vaccine. After spending \$600 million,  
19 USAID had not funded research that had led to a vaccine or made much progress on one. In fact, not only  
20 was this funding mechanism unsuccessful, it provided opportunities for corruption, and culminated in the  
21 indictment of the principal investigator for theft<sup>27,28</sup>.

#### 22 23 *Reducing the costs of clinical trials*

24 Another way to lower the costs of R&D is to change the requirements for NME approvals. This is one  
25 area in which costs have grown exponentially over the last half of the 20<sup>th</sup> century. The approval time for  
26 a new antibiotic has been increasing steadily since the last half of the 20<sup>th</sup> century, even with legislation  
27 that has reduced the average time of development.

28  
29 As mentioned previously, the increase in R&D costs is multi-faceted. However, much of this increase can  
30 be attributed to an increase in regulation. Increases in the regulation burden originated from legislation  
31 such as the 1962 Kefauver-Harris Amendments to the 1938 Food, Drug, and Cosmetics Act (FDCA).  
32 Although the monetary values for the cost of this regulation depend on the underlying assumptions of the  
33 estimate, the costs of clinical trials is estimated to have grown by 11.8 percent annually since 1980,  
34 compared with an annual growth rate of 2.3 percent for preclinical development. Another study estimates  
35 that the amendments to the FDCA increased the cost of developing a new drug by 2.3 times. When  
36 estimating the costs of regulation, it is important to consider that they also delay the introduction of  
37 NMEs as well as reduce the number of drugs that are introduced<sup>29</sup>.

38  
39 Although the benefits and costs of the increased regulatory burden will be discussed in later sections,  
40 programs that allow for a more rapid approval of novel antibiotics may be useful. One such program is  
41 the Food and Drug Administration's (FDA) Fast Track program, which is viewed as being of similar  
42 effectiveness as tax incentives in developing new drugs. Versions of the Fast Track programs have  
43 existed since the 1980s and have been included in the Medicare Modernization Act of 2003. The Fast  
44 Track program was intended to lower the cost of bringing a drug to market by basing approvals on  
45 surrogate end points, rolling submissions of applications for marketing approval, and selecting NME  
46 applications for priority review<sup>30</sup>.

47  
48 A subset of Fast Track is known as "accelerated review." Accelerated review is reserved for only the  
49 most serious diseases. If a drug is granted priority review status, the FDA must review the application in  
50 less than six months<sup>31</sup>. Under this program, NME can be approved after completing only a Phase II trial.  
51 Phase II trials typically rely on data based on a few hundred patients, rather than the thousands used in

1 Phase III trials. This substantially lowers the cost of clinical trials because a large proportion of R&D  
2 expenditures are spent on the lengthy clinical trials required by the FDA<sup>32</sup>.

3  
4 Although it may be beneficial to reduce the length of the FDA approval process, there is concern that a  
5 shorter approval process may lead to an increase in adverse drug events (ADEs), which are events that  
6 lead to hospitalizations or death. Much of the data on the effect of shorter approval times is based on the  
7 effects of the 1992 Prescription Drug User Fee Act (PDUFA). Under PDUFA, the FDA assesses fees on  
8 certain NME applications and is expected to meet specific performance goals in terms of approval times  
9 and number of NME applications reviewed. According to the Government Accounting Office (GAO), the  
10 FDA was able to reduce the time of a NME application from 27 months in 1993 to 14 months in 2001<sup>33</sup>.

11  
12 The results of these studies have found mixed results, but a majority of studies have shown there to be  
13 minimal effect, if any, on drug approval times and ADEs. Studies by Olson in 2000, 2002, and 2007,  
14 have shown an increase in serious ADEs. Olson suggests that drugs developed under PDUFA have had  
15 60 to 84 percent more ADEs. She also found that drugs developed under PDUFA had a similar increase  
16 in the number of deaths caused as drugs developed under the standard approval process<sup>34,35</sup>.

17  
18 There have been a number of studies, however, disagreeing with these findings. The GAO found that  
19 there were no significant differences between ADEs caused by drugs that qualified for Fast Track  
20 approval and those that did not. Separate studies by the FDA's Center for Drug Evaluation and Research  
21 and the Tufts Center for the Study of Drug Development have not found there to be any changes in  
22 adverse drug events since the passage of PDUFA. Another study used the percentage of drugs withdrawn  
23 from the market as an indicator of the FDA's ability to study a drug's ADEs prior to its release. This  
24 study showed that the percentage of drugs withdrawn post-PDUFA was the same as pre-PDUFA<sup>36</sup>. In a  
25 comprehensive review of the subject, the authors conclude that there was not an increase in "expected"  
26 ADEs since the enactment of PDUFA. The authors suggest that the findings by Olson can be explained  
27 by the fact that many more drugs have been approved with a black box warning already in place and that  
28 the number of "unexpected" ADEs, which is a more appropriate indicator of FDA performance, has not  
29 increased. Further, they suggest that PDUFA has led to pharmaceutical firms releasing drugs in the U.S.  
30 in advance of foreign countries. This prevents the FDA from using data obtained from the experience in  
31 other countries to influence their decisions on approving a new drug.

32  
33 The reason for the absence of new adverse drug events can be attributed to the increase in funding,  
34 staffing, and resources provided to the FDA from the funds raised by the PDUFA. Also, an increase in  
35 ADEs should not be attributed to inappropriate approvals by the FDA, if the FDA acknowledged the  
36 possibility of the ADE and appropriately warned the public about them. In fact, the number of new drugs  
37 launched with black box warnings has significantly increased. A study to quantify the benefits and costs  
38 of PDUFA found that PDUFA saved the equivalent of 180,000 to 310,000 life-years and that at the most,  
39 56,000 life-years were lost due to this legislation<sup>37</sup>.

#### 40 41 **Pull incentives**

42 In addition to the push incentives mentioned, pull incentives provide an alternative mechanism to  
43 stimulating pharmaceutical R&D. By increasing the expected return on a NME, pull incentives provide  
44 another avenue to increase R&D expenditures on drugs targeted to combat ARIs. Perhaps the most  
45 attractive aspect of pull incentives is that they cost the government, and tax payers, nothing unless a drug  
46 is developed<sup>38</sup>.

#### 47 48 *Patent extensions/market exclusivity*

49 Two possibilities that may work very well for stimulating R&D are market exclusivity and/or extension  
50 of patent protection. Two pieces of legislation to incorporate market exclusivity were the ODA and the  
51 Food and Drug Administration Modernization Act (FDAMA). The ODA provided seven years of market  
52 exclusivity for qualifying drugs, whereas the FDAMA provided firms six months of market exclusivity

1 for an approved drug in exchange for examining the effects of their medications on pediatric  
2 populations<sup>39</sup>. According to the FDA, the seven-year market exclusivity period in the ODA was “the  
3 most sought after incentive” by pharmaceutical firms<sup>40,41</sup>. Market exclusivity differs from patent  
4 protection in that it covers medicines that have either lost patent protection or are ineligible for patent  
5 protection. Market exclusivity is especially valuable for biopharmaceutical firms because many of their  
6 new drugs are “natural” and therefore ineligible for patents.

7  
8 It should be noted that not only do increases in patent protection duration increase investment in  
9 antibiotics, but that patents may also directly reduce the development of antibiotic-resistant strains.  
10 Horowitz and Moering, show that antibiotic resistance increases when antibiotics lose patent protection.  
11 They suggest that this is due to an increase in supply of the antibiotic and a concordant decrease in the  
12 price of the drug, which leads to an increase in resistance because the antibiotic is used more frequently  
13 and perhaps more inappropriately<sup>42</sup>.

#### 14 15 *Patent transfers*

16 A similar incentive is the ability to transfer patent protection rights of the new antibiotic to another drug  
17 produced by the firm that is more profitable. In this option, a pharmaceutical firm would be able to extend  
18 the patent of a more profitable drug in exchange for surrendering patent protection on the antibiotic. A  
19 model for this type of incentive was included in the FDA Modernization Act (FDAMA). The FDAMA  
20 provided a medication six months of market exclusivity if the pharmaceutical firm would conduct clinical  
21 trials of the drug on children if a written request were issued by the FDA. By specifying which pediatric  
22 diseases would qualify and specific time period for patent extension, the FDAMA provided clear  
23 incentives for pharmaceutical firms.

24  
25 It is important for the benefits of a transfer incentive to be clear from the outset and not be negotiated.  
26 Negotiated incentives may distort incentives for pharmaceutical firms and not address the most pressing  
27 needs. Similarly, it may provide incentives for the government to not appropriately reward a firm once  
28 the drug is developed. Therefore, clear incentives will allow pharmaceutical firms to decide which drugs  
29 to invest in and the government to provide appropriate incentives based on the needs of the drug.

#### 30 31 *Inappropriate pull incentives*

32 There are several pull incentives that do not readily apply to the development of pharmaceuticals in the  
33 developed world. In general, these incentives subsidize the purchase of medications in areas where a  
34 viable market does not exist. A viable market exists in places such as the United States and Europe for a  
35 variety of reasons, but especially because of the price inelasticity of drugs due to third party payer  
36 systems. Therefore, subsidized purchase programs should be restricted to areas in which the antibiotic  
37 treatment of an infection already exists, but the market is unable to pay for the drug, such as malarial  
38 drugs<sup>43</sup>.

39  
40 Another “pull incentive” that is probably not appropriate for stimulating antibiotic R&D is advanced  
41 market agreements (AMAs). AMAs are a guarantee by a government, non-governmental organization, or  
42 private firm to purchase a set amount of antibiotic, regardless of the actual market conditions once the  
43 drug is developed. Although these agreements have been described as essential in stimulating R&D for  
44 drugs and vaccines targeted for diseases primarily affecting the developing world, these would be difficult  
45 to develop for drugs targeted at ARPs<sup>44,45</sup>. One reason for this is the difficulty of predicting the potential  
46 prevalence or virulence of a new strain. For instance, in 1992, there were only 2,000 reported cases of  
47 MRSA, yet by 2005, there were nearly 400,000 cases, a number that had tripled since 2004<sup>46</sup>. This rapid  
48 growth could not have been predicted accurately, especially since the spread occurred decades after  
49 MRSA was first isolated. Because of this uncertainty, the government or other guarantors is likely to  
50 over commit or under commit, the former leading to wasted investment and the latter leaving the public  
51 vulnerable.

1 In aggregate, pull incentives would have to be significant in order to convince firms to invest in research  
2 for a novel antibiotic. Kremer estimates that nearly \$500 million in expected returns is necessary.  
3 However, the expected returns can be much lower if the research and development costs are lowered  
4 through push incentives<sup>47</sup>.

### 6 **AMA policy on incentives to promote the development of new antibiotics**

7 Existing AMA policy does not specifically address the role that artificial market incentives – either push  
8 or pull – might play in dealing with the problem of antibiotic resistance. Although the AMA supports  
9 what is essentially an FDA-funded, general R&D push incentive (grant programs that “encourage through  
10 appropriate funding a few research efforts investigating those drugs for which there may be no mass  
11 market, but which promise to fill an important need in rare but serious diseases” [H-100.993]), the AMA  
12 has not yet supported pull incentives. Furthermore, the AMA has not yet recognized the need for  
13 incentives to drive new antibiotic R&D. Consequently, new AMA policy supporting general mechanisms  
14 that would result in the timely development of novel antibiotics is warranted.

### 16 Public Health Initiatives

17  
18 Because the problem of antibiotic resistance is generally caused by poor public health practices,  
19 interventions that address these deficiencies may be more cost-effective than stimulating the development  
20 of novel antibiotics<sup>48,49</sup>.

21  
22 There is substantial evidence that the level of antibiotic resistance is largely determined by the use, or  
23 misuse, of antibiotics<sup>50</sup>. According to one study, “of the 51 million visits for ‘colds,’ upper respiratory  
24 tract infections, and bronchitis in the United States in one recent year, 50% to 66% culminated in an  
25 antibiotic prescription”<sup>51</sup>. Numerous other studies suggest that it is this over prescribing that is the key  
26 element in promoting antibiotic resistance<sup>\*52</sup>. There is also substantial evidence suggesting that improved  
27 prescribing behaviors will reduce the number of ARPs and the number of ARIs.

28  
29 Strategies for improving prescribing behavior have focused on changing physician’s prescribing behavior,  
30 changing patient attitudes towards the use of antibiotics, reforming the regulation of antibiotics, and  
31 creating a streamlined protocol for monitoring resistance and disseminating this information. Among  
32 strategies suggested have been educational interventions for both physicians and patients, increasing the  
33 use of computer-based practice tools, and using the Centers for Disease Control (CDC) as an information  
34 hub that would be responsible for tracking antibiotic-resistant strains.

35  
36 Although a number of interventions will be discussed, it is important to recognize that the end result of a  
37 successful intervention does not need to focus on complex system change, but rather that simple changes  
38 in behavior can actually be the most effective. For instance, hand washing remains the single most  
39 effective way to prevent nosocomial infections<sup>53</sup>. As a case study of the WIPes program at Johns  
40 Hopkins hospital illustrates, improving hand-washing practices by physicians and house staff reduced the  
41 number of MRSA infections in the Intensive Care Unit by 39 percent<sup>54</sup>.

### 43 **Provider education interventions**

44 A number of proposals to improve the prescribing behavior of physicians have been suggested. Because  
45 the evidence suggests that over-prescribing is driving ARIs, educational interventions that would help  
46 prevent these errors are at the foundation of any intervention. Potential areas of improvement include  
47 limiting the use of antibiotics to susceptible infections, avoiding prolonged, repeated use of antibiotics,  
48 and using first-line antibiotics<sup>55</sup>.

---

\* Hypotheses about the causes of over-prescribing are described in detail by a 2000 article by Avorn and Solomon<sup>51</sup>.

1 However, the success of educational interventions has been mixed, with a majority of studies indicating  
2 that the most commonly used interventions usually fail to have an impact. The success of educational  
3 interventions targeted at physicians and other providers appear to be dependent on five dimensions: 1) the  
4 type of intervention, 2) the outcome of interest, 3) the intensity of the intervention, 4) the quality of  
5 implementation, and 5) the setting of health facility<sup>56,57</sup>.

### 6 7 **Educational interventions**

8 Passive educational interventions such as unsolicited mailings, journal publications, and postings of  
9 recommendations near provider workstations have proven to be insufficient in changing physician  
10 behavior<sup>58-60</sup>. Large educational seminars or grand rounds are often used because they are convenient  
11 ways of reaching a large number of providers simultaneously. However, making small, temporary  
12 improvements in behavior is unlikely to have much impact on reducing the number of antibiotic-resistant  
13 pathogens<sup>61</sup>. More interactive, small group provider education seminars, have had better results. One  
14 study found that small group sessions were twice as effective as large seminars in changing provider  
15 prescribing behaviors<sup>62</sup>.

16  
17 Small group seminars have better success if they are coupled with a practice audit to evaluate the  
18 physicians' behavior. Audits typically include comparison of physician practices, review of prescribing  
19 outcomes following an intervention, and additional printed materials<sup>63</sup>. In a Cochrane review examining  
20 audits for changing physician behavior, studies indicated that the effects of audits are small and most  
21 effective in practices in which the need for improvement was most necessary. It should be noted that  
22 audits alone are ineffective and that coercive methods in general are consistently less effective than  
23 supportive incentives.

24  
25 A Finish study is an exception to the rule that passive interventions are unsuccessful. It demonstrated that  
26 the publication of a national practice guideline to convince physicians to prescribe penicillin, rather than  
27 macrolides, for certain infections could improve the use of first-line antibiotics. It appears that these  
28 effects continued following termination of the study. In a systematic review by the Cochrane Library, the  
29 authors suggest that this improvement was due to two reasons. First, it is easier to convince physicians to  
30 switch from one antibiotic to another compared to denying antibiotics to patients. Secondly, the concern  
31 about the use of macrolides was described in terms of patient safety, as growing macrolide resistance in  
32 Finland was contributing to increased patient mortality and morbidity<sup>64</sup>. The relative ease of convincing  
33 physicians to prescribe one antibiotic rather than another is evident in the success of many of the other  
34 types of public health programs described in the following sections.

35  
36 Perhaps the most successful educational interventions have been the use of detailers in a similar manner  
37 of that used by pharmaceutical companies to promote a new drug. A number of randomly controlled  
38 trials and cohort studies have shown these to be effective in a variety of practice settings. But these  
39 detailers are not always successful, as was shown in a Spanish randomly controlled trial<sup>65</sup>. In addition,  
40 there is some evidence that use of pharmacist detailers is superior to using physicians in these  
41 interventions<sup>66</sup>.

### 42 43 **Physician practice tools**

44 Using electronic reminders or practice tools has had inconsistent effects that depend on the quality of the  
45 intervention<sup>67</sup>. In a review of electronic reminders, once the reminders were terminated, so too were the  
46 correct prescribing practices. This finding suggests that these reminders eliminated "errors of omission"  
47 rather than led to new knowledge and behavior<sup>68</sup>. Although other practice tools have been developed,  
48 data is lacking to support their use.

### 49 50 **Educating patients on proper use of antibiotics**

51 Education of patients about the proper use of antibiotics should also be a target for interventions. Patients  
52 who have incorrect expectations about when they should be prescribed antibiotics can put pressures on

1 physicians to prescribe antibiotics unnecessarily. Studies analyzing the use of antibiotics in pediatric care  
2 showed that doctors prescribe antibiotics 65 percent of the time if they perceive parents expect them, but  
3 only 12 percent of the time if they feel parents do not expect them<sup>69</sup>. Studies have shown that isolated  
4 interventions, such as educational videos on unnecessary antibiotic use have only modest, if any, impact  
5 on patient behavior<sup>70</sup>. Package inserts could provide a simple education avenue for patients, but the  
6 effects tend to be inconsistent<sup>71</sup>.

### 7 **AMA policy on public health initiatives to decrease antibiotic resistance**

8 The AMA has substantial existing policy outlining various public health initiatives to decrease antibiotic  
9 resistance. The AMA's approach to decreasing antibiotic resistance centers on increased education at all  
10 levels, including the federal government and influential medical bodies educating the general public,  
11 physicians educating patients, and the AMA educating practicing physicians and physicians in training  
12 (H-100.973). Additionally, AMA policy encourages scientific research on antibiotic resistance (H-  
13 100.973) and directs the AMA to collaborate with multiple organizations on various initiatives to  
14 decrease antibiotic resistance (D-100.995, D-100.998). New AMA policy addressing public health  
15 initiatives to decrease antibiotic resistance is unnecessary.  
16

### 17 Conclusion

18  
19  
20 The purpose of this report was to determine the prevalence and impact of pathogens resistant to the  
21 current arsenal of antibiotics and to discuss strategies to reduce the morbidity and mortality caused by  
22 these infections. Currently, the number of infections caused by antibiotic resistant organisms has  
23 increased dramatically in the last twenty years with a large percentage of this growth occurring this  
24 century. Fortunately, these pathogens have caused relatively little damage compared to their potential.  
25

26 Because the potential damage caused by these organisms is tremendous, action should be taken to prevent  
27 large-scale epidemics. Immediate action should be taken because these resistant pathogens have proved  
28 to be elusive targets of novel antibiotics. Prompt action should reduce the likelihood of these problems.  
29

30 Although this report analyzed numerous mechanisms for stimulating pharmaceutical research and  
31 development, the most cost-effective and viable solutions will depend on changing the practices that  
32 promote the development of resistance. However, if these proposed prevention strategies fail, novel  
33 antibiotics will be necessary to treat these infections. Of the mechanisms available to stimulate antibiotic  
34 R&D, both push and pull incentives should be used. The former is preferred in the case of drugs targeted  
35 against antibiotic-resistant strains of bacteria because of the difficulty in predicting the cost of the post-  
36 market incentives. It is also recommended that legislation be modeled after the ODA, with simple  
37 redactions of the least effective policies and more emphasis on effective policies such as access to the  
38 "Fast Track" approval process and tax credits.  
39

40 The problem of antibiotic resistance will not go away with the development of new antibiotics, but can be  
41 curtailed with better public health practices. Empirical evidence suggests that interventions will need to  
42 be multi-faceted to have lasting impact. For instance, changing physician prescribing practices will need  
43 to involve intensive individual or small-group workshops in conjunction with practice audits and  
44 computer-based practice tools. Successful models have been demonstrated in a variety of practice  
45 settings, but require substantial investment of resources and time. Unfortunately, the hospitals and  
46 physician practices that successfully reduce the incidence and prevalence of ARPs may not get a full  
47 return on their investment, while others may "free-ride" on their success. Because of this problem, not  
48 only will the interventions need to involve a variety of strategies, but a variety of interested bodies will  
49 also need to be involved. The costs of a concerted effort may be large, but it appears that the overall  
50 expected returns make this a worthwhile and necessary investment.

## Recommendation

Your MSS Governing Council recommends that the following be adopted in lieu of MSS Resolution 18-A-08 and that the remainder of this report be filed:

1. That our AMA continue to monitor the spread of antibiotic resistance and, if deemed necessary, support mechanisms that would result in the timely development of novel antibiotics. Mechanisms should include a combination of push and pull incentives with legislation modeled after the Orphan Drug Act in conjunction with intensive educational efforts targeting physicians and patients.

## Acknowledgements

The MSS Committee on Public Health is Chaired by Jenny Guido and Vice Chaired by Tanvir Hussain. The Committee is additionally composed of Jacob Hartz, Emily Murphy, Karen Studer, and Sophia Tcheung.

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### **Appendix 1: Relevant AMA Policy**

#### **H-100.973 Combating Antimicrobial Resistance through Education**

Our AMA: (1) encourages the federal government, the World Health Organization, the World Medical Association, and the International Federation of Pharmacists to promote more effective education concerning the appropriate use of antibiotics;

(2) strongly urges physicians to educate their patients about their antimicrobial therapy, the importance of compliance with the prescribed regimen, and the problem of antimicrobial resistance;

(3) will continue to educate physicians and physicians-in-training about the appropriate prescribing of antimicrobial agents; (4) encourages the use of antibiotic resistance management programs; these education-based programs should be multidisciplinary and cooperative (i.e., including infectious disease physicians, infection-control specialists, microbiology laboratory personnel, and clinical pharmacists); and

(5) encourages continued scientific research on the issue of antibiotic resistance. (Sub. Res. 521, A-94; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation I-98; Modified: CSA Rep. 3, A-00; Reaffirmation I-07)

#### **D-100.995 Antimicrobial Use and Resistance**

Our AMA will work with other organizations to establish a national program to counter antibiotic resistance in clinical practice similar to the California Medical Association Foundation AWARE program. (Res. 508, A-01; Reaffirmation I-07)

#### **D-100.998 Combating Antibiotic Resistance Via Physician Action and Education: AMA Activities**

Our AMA will continue to collaborate with the appropriate federal agencies, other medical specialty societies, and other appropriate public health organizations to address the urgent problem of increasing antimicrobial resistance and its impact on public health. (CMS Rep. 3, A-00; Reaffirmation I-07)

#### **H-100.993 Recommendations on Drug Development and Drug Regulation**

(1) The FDA must be given the funds and quality personnel to perform its tasks effectively and efficiently. Career opportunities must be made more attractive in terms both of salary and scientific career opportunities. (2) The FDA should be encouraged to make use of foreign data generated by reputable foreign scientists. This would reduce the reduplicative efforts now required and avoid the questionable ethics of demanding clinical trials for strictly regulatory purposes. (3) The FDA should be encouraged to confer with industry and clinical investigators during the IND phase of drug application. Sponsors should design their protocols and report forms in collaboration with the FDA and the involved clinical investigators. Thus, the pharmaceutical company sponsor may be secure in the knowledge that the early clinical trials so constructed will provide the FDA with information necessary to its new drug application. (4) The FDA should develop a system of grants that will encourage through appropriate funding a few research efforts investigating those drugs for which there may be no mass market, but which promise to fill an important need in rare but serious diseases. (5) The AMA supports the funding of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (CSA Rep. B, Parts 1, 2, 4, 5, I-78; Reaffirmed: CLRPD Rep. C, A-89; BOT Rep. 32, I-94; Reaffirmed and Modified: CSA Rep. 6, A-04)