We are pleased to provide the following items received in addition to those included in the advance Delegate’s Handbook.

**Reports**
- BOT 11 Anti-Harassment Policy (Info. Report)
- CC&B 01 Amended Bylaws - Specialty Society Representation - Five Year Review (Amendments to Constitution and Bylaws)
- CEJA 01 Competence, Self-Assessment and Self-Awareness (Amendments to Constitution and Bylaws)
- CEJA 04 Mergers of Secular and Religiously Affiliated Health Care Institutions (Amendments to Constitution and Bylaws)
- CLRPD 01 Senior Physicians Section Five-Year Review (F)
- CME 01 Promoting and Reaffirming Domestic Medical School Clerkship Education (K)
- CME 03 Impact of Immigration Barriers on the Nation’s Health (Info. Report)
- CMS 01 Affordable Care Act Section 1332 Waivers (J)
- CMS 02 Hospital Surveys and Health Care Disparities (J)
- CMS 04 Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients (J)
- CSAPH 05 Clinical Implications and Policy Considerations of Cannabis Use (K)
- CMS/CSAPH 01 Payment and Coverage for Genetic/Genomic Precision Medicine (J)

**Resolutions Recommended for Consideration**
- 005 Protection of Physician Freedom of Speech
- 006 Physicians' Freedom of Speech
- 218 Health Information Technology Principles
- 219 Certified EMR Companies' Practice of Charging Fees for Regulatory Compliance
- 220 Preserving Protections of the Americans with Disabilities Act of 1990
- 221 House of Representative Bill HR 2077, Restoring the Patient's Voice Act of 2017
- 222 The Clinical Use of a Home Sleep Apnea Test
- 223 Treating Opioid Use Disorder in Correctional Facilities
- 224 Modernizing Privacy Regulations for Addiction Treatment Records
- 225 Oppose Inclusion of Medicare Part B Drugs in QPP / MIPS Payment Adjustment
- 226 Prescription Drug Importation for Personal Use
- 814 Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments
- 815 Pediatric Representation for E/M Documentation Guideline Revision
- 816 Social Determinants of Health in Payment Models
- 817 Addressing the Site of Service Deferential
• 818 On-Call and Emergency Services Pay
• 819 Consultation Codes and Private Payers
• 820 Elimination of the Laboratory 14-Day Rules Under Medicare
• 821 Hormonal Contraception as a Preventive Service
• 911 State Maternal Mortality Review Committees
• 912 Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act
• 913 Increased Death Rate and Decreased Life Expectancy in the United States
• 914 Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures
• 959 Lifestyle Medicine Education in Medical School Training and Practice

Finally, your Speakers wish to inform you that the charts listing actions taken in follow-up to resolutions and report recommendations from the 2016 Interim and 2017 Annual Meetings will be posted on the Interim Meeting website (www.ama-assn.org/interim-meeting).

Sincerely,

Susan R. Bailey, MD  
Speaker, House of Delegates

Bruce A. Scott, MD  
Vice Speaker, House of Delegates
At the 2017 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted Policy H-140.837, “Anti-Harassment Policy” (see Appendix for full text), which provided that:

Upon adoption of the Anti-Harassment Policy, the Board will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident. Additionally, the Board will consider and prepare for future consideration by the HOD, potential corrective action and/or discipline for conduct in violation of this policy, which may include, but shall not be limited to, referral of the matter to the applicable delegation, expulsion from AMA meetings, or expulsion from the HOD.

The policy was proffered by Board of Trustees Report 23-A-17, which noted that AMA Human Resources policies establish zero tolerance regarding harassment with respect to AMA personnel, agents, and nonemployees, including AMA members. This informational report of the Board of Trustees provides an update to the House of Delegates. At the 2018 Annual Meeting, the Board will recommend procedures to fully implement the anti-harassment policy with respect to conduct during meetings of the House of Delegates, councils, sections, and all other AMA entities, such as the RVS Update Committee (RUC) and CPT Editorial Panel.

DISCUSSION

Professional associations’ anti-harassment policies are designed to support the open exchange of ideas central to their mission and to ensure that those who participate in association activities “enjoy an environment free from all forms of discrimination, harassment, and retaliation” [1]. Surprisingly few professional associations have published anti-harassment policies. These associations have established mechanisms to address allegations of harassment that designate the association officer(s) or other association authority to whom incidents should be reported, provide for confidential investigation of alleged inappropriate conduct, and define sanctions that may be imposed if conduct is found to violate association policy [1-5].

The AMA recently extended mandatory recurring anti-harassment training to include not only staff, but also members of all AMA councils. The Board believes such training is appropriate for section governing councils and Board members as well. It is the Board’s hope that this training will eliminate harassing behavior in connection with meetings of AMA entities, but given our zero tolerance policy for such behavior we believe that a formal process for reporting, investigation and resolution should be established.

There are numerous complexities involved in implementing processes for reporting and investigation and discipline in the event of harassment complaints. The Board is studying best practices and reviewing potential avenues for the above called for in Policy H-140.837. Myriad issues have arisen with any of the types of processes discussed. Thus, the Board will make recommendations on reporting, investigating, and enforcing instances of harassment at the 2018 Annual Meeting.
REFERENCES


APPENDIX

AMA Policy H-140.837, “Anti-Harassment Policy”

1. Our AMA adopts the following policy:

**Anti-Harassment Policy Applicable to AMA Entities**

It is the policy of the American Medical Association that any type of harassment of AMA staff, fellow delegates or others by members of the House of Delegates or other attendees at or in connection with HOD meetings, or otherwise, including but not limited to dinners, receptions and social gatherings held in conjunction with HOD meetings, is prohibited conduct and is not tolerated. The AMA is committed to a zero tolerance for harassing conduct at all locations where AMA delegates and staff are conducting AMA business. This zero tolerance policy also applies to meetings of all AMA sections, councils, committees, task forces, and other leadership entities (each, an “AMA Entity”), as well as other AMA-sponsored events.

**Definition**

Harassment consists of unwelcome conduct whether verbal, physical or visual that denigrates or shows hostility or aversion toward an individual because of his/her race, color, religion, sex, sexual orientation, gender identity, national origin, age, disability, marital status, citizenship or other protected group status, and that: (1) has the purpose or effect of creating an intimidating, hostile or offensive environment; (2) has the purpose or effect of unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity; or (3) otherwise adversely affects an individual’s participation in such meetings or proceedings or, in the case of AMA staff, such individual’s employment opportunities or tangible job benefits.

Harassing conduct includes, but is not limited to: epithets, slurs or negative stereotyping; threatening, intimidating or hostile acts; denigrating jokes; and written, electronic, or graphic material that denigrates or shows hostility or aversion toward an individual or group and that is placed on walls or elsewhere on the AMA’s premises or at the site of any AMA meeting or circulated in connection with any AMA meeting.

**Sexual Harassment**

Sexual harassment also constitutes discrimination, and is unlawful and is absolutely prohibited. For the purposes of this policy, sexual harassment includes:
• making unwelcome sexual advances or requests for sexual favors or other verbal, physical, or visual conduct of a sexual nature; and
• creating an intimidating, hostile or offensive environment or otherwise unreasonably interfering with an individual’s participation in meetings or proceedings of the HOD or any AMA Entity or, in the case of AMA staff, such individual’s work performance, by instances of such conduct.

Sexual harassment may include such conduct as explicit sexual propositions, sexual innuendo, suggestive comments or gestures, descriptive comments about an individual’s physical appearance, electronic stalking or lewd messages, displays of foul or obscene printed or visual material, and any unwelcome physical contact.

Retaliation against anyone who has reported harassment, submits a complaint, reports an incident witnessed, or participates in any way in the investigation of a harassment claim is forbidden. Each complaint of harassment or retaliation will be promptly and thoroughly investigated. To the fullest extent possible, the AMA will keep complaints and the terms of their resolution confidential.

2. Our AMA’s Board of Trustees will establish a formal process by which any delegate, AMA Entity member or AMA staff member who feels he/she has experienced or witnessed conduct in violation of this policy may report such incident; and consider and prepare for future consideration by the House of Delegates, potential corrective action and/or discipline for conduct in violation of this policy, with report back at the 2017 Interim Meeting.
Subject: Amended Bylaws – Specialty Society Representation – Five-Year Review

Presented by: Colette R. Willins, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

At the 2017 Annual Meeting, the House of Delegates considered Board of Trustees Report 25, “Specialty Society Representation in the House of Delegates – Five-Year Review.” Among its recommendations was that two societies which failed to meet the requirements for continued representation after a year’s grace period to increase membership should not retain representation in the House of Delegates. Testimony at the Reference Committee on Amendments to Constitution and Bylaws, however, supported maintaining the inclusion of these two societies. Testimony lauded the groups’ growths in membership and their participation within the AMA, and maintained that the loss of these societies would be detrimental to the AMA. Both societies presented materials to the reference committee outlining their considerable efforts to increase membership. Based on the testimony presented, the Reference Committee on Amendments to Constitution and Bylaws recommended that the societies retain their representation.

The House of Delegates disagreed and chose to adopt amended language as follows, “Having failed to meet the requirements for continued representation in the AMA House of Delegates as set forth in AMA Bylaw B-8.5 after a year’s grace period [both societies]…. be allowed only one additional year to meet these requirements.” The following day, the House reconsidered this item of business because our current Bylaws do not contain an option for the House to extend a second one-year grace period. Ultimately, the House returned to the original BOT Report 25-A-17 recommendation to not retain the representation of these two societies in the House of Delegates. Although the AMA Bylaws do allow the House to continue the representation of a society that does not meet the current guidelines for representation, some testified that this is unfair to those societies that have faced similar membership challenges but succeeded in regaining membership during the one-year grace period. Lastly, a representative of the Specialty and Service Society (SSS) stated that, per the AMA Bylaws, each of the two societies, though they would not retain representation in the HOD, would continue as a member of the SSS and may apply for reinstatement in the House, through the SSS, when they believe they can comply with the guidelines for representation in the House of Delegates.

The Council on Constitution and Bylaws volunteered to look at the existing bylaws and bring forth a report back to the House.

HISTORICAL PERSPECTIVE/CURRENT STATUS

As part of its due diligence, the Council examined the origin of direct specialty society representation in the AMA House of Delegates. Specialty societies were first directly represented in the House of Delegates in 1977. Ten years later in 1987, there were major changes, including
guidelines for evaluating applications for representation and establishing a five-year review to ensure continued compliance with the guidelines.

The first instance of noncompliance arose in 1989. Subsequently the House, through the Council on Long Range Planning and Development (CLRPD), began to consider various options, including a grace period, automatic disqualification of the specialty organization, and a probationary period without voting privileges. It took three meetings for the House to ultimately agree on bylaw language that provided for an automatic one-year grace period to allow noncompliant societies time to become compliant, another review of the society a year later, and the following three options for House action on any society that remained noncompliant after the one-year grace period: 1) continued representation; 2) termination of representation; or 3) a year of probation defined as suspension from active representation, with the society on probation not having a voting delegate in the House or the privilege of the floor, but continued representation in the Specialty Section Council. During the probation period, one final review of the society’s compliance with the current guidelines would occur. If the specialty organization failed to bring itself into compliance, it then would automatically be terminated from representation in the House of Delegates.

In 1993, the House adopted CLRPD Report B-A-93, which provided substantive recommendations for restructuring the House of Delegates. This report also established the Specialty and Service Society (SSS) as the entity responsible for providing a process for: 1) granting specialty organization representation in the House; 2) periodic review of the qualifications of specialty organizations for retention of representation; and 3) a mechanism for terminating, when appropriate, the representation of a specialty organization in the House. The work of SSS is overseen by an 8-person governing council, which is elected by the SSS membership. CCB Report 2-A-94 provided the bylaw amendments to implement the mechanism by which specialty organizations were admitted to the House and by which they maintained their representation, but deleted the previous bylaw language providing for automatic termination after the one-year probationary period.

Under the current Bylaws, all specialty societies are reviewed on a five-year cycle to determine compliance with the current guidelines as stated in AMA policy (Policy G-600.020). The Bylaws provide noncompliant societies with a one-year grace period during which it is hoped that they are able to bring themselves into compliance. At the end of that period, the House has only two options for acting on societies that remain noncompliant after the one-year grace period: 1) continue the society’s representation; or 2) discontinue the society’s representation.

The appended chart shows the evolution of specialty society representation once the five-year review was put into place, offers more details regarding amendments over time to the AMA Bylaws to address noncompliant societies, and provides background on House actions on noncompliant societies. In short, since 1989 there have been 69 societies that did not meet the guidelines for continued representation, with House action characterized as follows:

- Society compliant after grace period – 38
- Society noncompliant/representation continued – 17
- Society noncompliant/representation terminated – 7 (two of these societies were subsequently readmitted)
- Other action – 7 (society dissolved, society merged with another, etc.)

It must also be noted that 10 years ago, a fairly large number of societies up for review were no longer able to meet the current guidelines for representation due to declining AMA membership among their own specialty society membership. The House placed a moratorium on loss of
representation, and in 2008 subsequently adopted modified membership criteria, which were again amended in 2012 and embodied in Policy G-600.020 (3).

DISCUSSION

The Council identified and discussed several elements it believed were not clearly addressed in current AMA Bylaws and convened a conference call with members of the SSS Governing Council. Discussion points included:

1) When does a specialty society’s termination from representation in the House of Delegates take effect?

Historically, the loss of representation has occurred at the conclusion of the meeting rather than immediately following the House’s action to unseat. This seems fair to the Council, as any organization with a one-year grace period that is invested enough in the outcome to send a representative without knowing the outcome in advance should not be penalized by immediately losing their seat or voting privileges. An amendment to the Bylaws to this effect has been proposed for House action.

2) When does the next five-year review occur for a noncompliant society when the House votes to continue its representation in the House after a one-year grace period?

Every specialty admitted to the House of Delegates is on a five-year review cycle. In the past, SSS has maintained the original five-year review schedule. Thus, when the House votes to continue the representation of a noncompliant society after a grace period, the specialty society retains representation in the House of Delegates until its next scheduled review with no additional scrutiny or reporting. The Council has proposed Bylaw language to make this clearer.

3) What actions, if any, beyond those in the current Bylaws should the House be empowered to take when faced with a society that remains noncompliant after its one-year grace period?

Both the Council and the SSS agree that it is the responsibility of the House to decide to either continue the membership with another review in 4 years or to terminate the society’s representation. In the past, the House has been inconsistent in its actions, often being swayed by passionate testimony during reference committee and again on the floor of the House on why a society should not lose its representation. In light of the recent parity in representation between constituent societies and specialty societies, essentially any noncomforming society whose representation is continued is taking a seat from another specialty society that has met all requirements for continued representation. SSS members expressed hopes that the House would be judicious in actions to continue the representation of any society that is noncompliant, reserving the vote for continuation only for extenuating circumstances. Also, per existing AMA Bylaw 8.5.3.2.2, if the House votes to terminate a specialty society’s representation in the House, they still remain members of the Specialty and Service Society. A society, which worked hard during its grace period but did not reach its goal but that continued its outreach efforts, likely would be without an HOD delegate seat for less than one year even recognizing that new societies are only admitted at the Annual Meeting. The Council believes the options currently provided in the Bylaws should remain as the only options.
RECOMMENDATIONS

The Council on Constitution and Bylaws recommends that the following amendments to the AMA Bylaws be adopted and that the remainder of this report be filed. Adoption requires the affirmative vote of two-thirds of the members of the House of Delegates present and voting.

8.5 Periodic Review Process. Each specialty society and professional interest medical association represented in the House of Delegates must reconfirm its qualifications for representation by demonstrating every 5 years that it continues to meet the current guidelines required for granting representation in the House of Delegates, and that it has complied with the responsibilities imposed under Bylaw 8.2. The SSS may determine and recommend that societies currently classified as specialty societies be reclassified as professional interest medical associations. Each specialty society and professional interest medical association represented in the House of Delegates must submit the information and data required by the SSS to conduct the review process. This information and data shall include a description of how the specialty society or the professional interest medical association has discharged the responsibilities required under Bylaw 8.2.

8.5.1 If a specialty society or a professional interest medical association fails or refuses to provide the information and data requested by the SSS for the review process, so that the SSS is unable to conduct the review process, the SSS shall so report to the House of Delegates through the Board of Trustees. In response to such report, the House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates by majority vote of delegates present and voting, or may take such other action as it deems appropriate.

8.5.2 If the SSS report of the review process finds the specialty society or the professional interest medical association to be in noncompliance with the current guidelines for representation in the House of Delegates or the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will have a grace period of one year to bring itself into compliance.

8.5.3 Another review of the specialty society’s or the professional interest medical association’s compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2 will then be conducted, and the SSS will submit a report to the House of Delegates through the Board of Trustees at the end of the one-year grace period.

8.5.3.1 If the specialty society or the professional interest medical association is then found to be in compliance with the current guidelines for representation in the House of Delegates and the responsibilities under Bylaw 8.2, the specialty society or the professional interest medical association will continue to be represented in the House of Delegates and the current review process is completed. The next review will occur four years from the time of the House’s action to continue representation.

8.5.3.2 If the specialty society or the professional interest medical association is then found to be in noncompliance with the current guidelines for representation in the House of Delegates, or the responsibilities under Bylaw 8.2, the House may must take one of the following actions:
8.5.3.2.1 The House of Delegates may continue the representation of the specialty society or the professional interest medical association in the House of Delegates, in which case the result will be the same as in Bylaw 8.5.3.1. The next review will occur four years from the time of the House’s action to continue representation after a one-year grace period.

8.5.3.2.2 The House of Delegates may terminate the representation of the specialty society or the professional interest medical association in the House of Delegates effective with the adjournment of the House of Delegate meeting at which action takes place. The specialty society or the professional interest medical association shall remain a member of the SSS, pursuant to the provisions of the Standing Rules of the SSS. The specialty society or the professional interest medical association may apply for reinstatement in the House of Delegates, through the SSS, when it believes it can comply with all of the current guidelines for representation in the House of Delegates.
RELEVANT AMA POLICY

G-600.020, “Admission of Specialty Organizations to our AMA House”
The following guidelines shall be utilized in evaluating specialty society applications for representation in our AMA House of Delegates (new specialty organization applications will be considered only at Annual Meetings of the House of Delegates):
(1) The organization must not be in conflict with the Constitution and Bylaws of our AMA with regard to discrimination in membership;
(2) The organization must: (a) represent a field of medicine that has recognized scientific validity; (b) not have board certification as its primary focus; and (c) not require membership in the specialty organization as a requisite for board certification;
(3) The organization must meet one of the following criteria: (a) a specialty organization must demonstrate that it has 1,000 or more AMA members; or (b) a specialty organization must demonstrate that it has a minimum of 100 AMA members and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA; or (c) a specialty organization must demonstrate that it was represented in the House of Delegates at the 1990 Annual Meeting and that twenty percent (20%) of its physician members who are eligible for AMA membership are members of the AMA;
(4) The organization must be established and stable; therefore it must have been in existence for at least five years prior to submitting its application;
(5) Physicians should comprise the majority of the voting membership of the organization.
(6) The organization must have a voluntary membership and must report as members only those who are current in payment of dues, have full voting privileges, and are eligible to hold office;
(7) The organization must be active within its field of medicine and hold at least one meeting of its members per year;
(8) The organization must be national in scope. It must not restrict its membership geographically and must have members from a majority of the states;
(9) The organization must submit a resolution or other official statement to show that the request is approved by the governing body of the organization;
(10) If international, the organization must have a US branch or chapter, and this chapter must be reviewed in terms of all of the above guidelines.

G-600.019, “Probationary Period for Specialty Societies”
The specialty organizations placed on one year probation are expected to work with AMA membership to develop a plan to increase their AMA membership and meet the responsibilities of National Medical Specialty Organizations as provided in Section 8.20 of the Bylaws. Our AMA will work towards implementation of data licensing agreements with the specialty organizations seated in the House of Delegates that will provide them with the ability to view a portion of the AMA eprofile application for the sole purpose of AMA membership verification.
## History of Specialty Societies noncompliant with AMA-HOD Representation Criteria and House Action

<table>
<thead>
<tr>
<th>Society and Year of Initial Review for Compliance (and Year of Admittance)</th>
<th>Outcome/Comments</th>
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<tbody>
<tr>
<td>1989</td>
<td>BOT Report DDD-A-89, in its review of the third group of specialty organizations seated in the HOD, noted the first society not in compliance. The Board was asked to develop a mechanism to address specialty society noncompliance and report back at I-89. CCB Report A-I-89, proposed a process, including a one-year grace period, to permit the House of Delegates to take direct action when a deficiency was discovered in the process of the five-year review, but it was referred back, as was CCB Report A-A-90. Ultimately adopted was CCB Report I-I-90 with its proposal that (1) there will be a verification of AMA membership of the specialty organization, and notification of the results of the review process provided to the specialty organization approximately one year prior to the BOT’s report to the House; (2) A specialty organization found to be noncompliant will have one year, from the time of the Board’s report to the HOD, to bring itself into compliance with the guidelines. At the end of the grace period of one year, the Board will submit another report advising the House as to the specialty organization’s compliance. If the organization is not in compliance, the House will have the option of voting to continue the representation of the specialty organization in the HOD, to terminate the representation in the HOD or to place the specialty organization on a probationary status for a period of one year. (Probationary status is defined as suspension from active representation. A society on probation would not have a voting delegate and would not have the privilege of the floor, but would be entitled to continue to have representation in the specialty Section Council.) If the HOD grants a one-year period of probationary status, the BOT shall report one year later, in an informational report, on the organization’s compliance with the guidelines for representation. If the organization has failed to bring itself into compliance, it will be automatically terminated from representation in the House. CCB Report E-A-91 with the bylaw amendments was adopted.</td>
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<td>American Association of Pathologists (1977)</td>
<td>A-89: No “official probation,” but BOT reported it would again review membership data in 1990. BOT Report CCC-A-90 was adopted with the recommendation that AAP’s representation be suspended at the conclusion of the 1990 Annual Meeting for a 2-year period, during which the AAP may be readmitted to representation in the HOD if it cures the cited deficiency and brings itself into compliance with the Guidelines for Representation in the House. At the conclusion of said two year period if the cited deficiency has not been corrected the representation of the AAP will be terminated.</td>
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<td>Year</td>
<td>Society Name</td>
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<tr>
<td>1991</td>
<td>American Society of Clinical Pharmacology and Therapeutics (1977)</td>
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<td></td>
<td>American Pediatric Surgical Association (1986)</td>
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<tr>
<td>1992</td>
<td>No noncompliant societies</td>
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<td>1993</td>
<td>No noncompliant societies</td>
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<td>1994</td>
<td>National Association of Medical Examiners (1983)</td>
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<td></td>
<td>American College of Legal Medicine (1984)</td>
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<td>Year</td>
<td>Organization</td>
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<tr>
<td>1999</td>
<td>Association of University Radiologists (1989)</td>
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<tr>
<td>2000</td>
<td>No noncompliant societies</td>
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<td></td>
<td>American College of Rheumatology (1987) [Admitted as the American Rheumatism Association]</td>
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<td></td>
<td>Society of Nuclear Medicine (1979)</td>
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| **2006** | **American College of Medical Genetics \& Genomics (1996)**  
[Admitted as American College of Medical Genetics] | **At A-06, the House adopted Resolution 603 that called for a moratorium on the loss of any organization’s current representation in the HOD for any society which does not meet the current AMA guidelines for representation requirements as it pertains to the percentage of AMA members; that the moratorium remain in place through December 31, 2007; and when the moratorium is lifted any organization which does not meet the required percentage of AMA members will have a one year grace period to meet the requirements for HOD representation.**  
  
**A-06:** Placed on a one-year grace period for review.  
**I-07:** Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance.  
**I-08:** Representation retained (compliant with new membership threshold). |
| **American Pediatric Surgical Association (1986)** | **A-06:** Placed on a one-year grace period for review.  
**I-07:** Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance.  
**I-08:** Representation continued (compliant with new membership threshold). |
| **American Society of Bariatric Physicians (2001)** | **A-06:** Placed on a one-year grace period for review.  
**I-07:** Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance.  
**I-08:** Representation continued (compliant with new membership threshold). |
| **American Society of Colon and Rectal Surgeons (1977)** | **A-06:** Placed on a one-year grace period for review.  
**I-07:** Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance.  
**I-08:** Representation continued (compliant with new membership threshold). |
| **American Society of Neuroimaging (1996)** | **A-06:** Placed on a one-year grace period for review.  
**I-07:** Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance.  
**I-08:** Representation continued (compliant with new membership threshold). |
| **American Society of Neuroradiology (1986)** | **A-06:** Placed on a one-year grace period for review.  
**I-07:** Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance.  
**I-08:** Representation continued (compliant with new membership threshold). |
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<tr>
<th>Organization</th>
<th>2007</th>
<th>2008</th>
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<tr>
<td>Academy of Pharmaceutical Physicians and Investigators (2002)</td>
<td>A-07: Did not submit materials (aware it will automatically be placed on probation at the end of the moratorium on December 31, 2007, and will be required to go through the five-year review process in 2008. Representation retained at this time, but will be reviewed again at the end of the moratorium and will be required to comply with the membership requirements at that point, or be given one year to come into compliance.</td>
<td>I-08: Representation continued (compliant with new membership threshold).</td>
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<td>Society of Nuclear Medicine (1979)</td>
<td>I-07: Placed on a one-year grace period for review at the AMA’s 2008 Interim Meeting.</td>
<td>I-08: Noncompliance noted but the House voted to continue their representation.</td>
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<tr>
<td>2008</td>
<td>The House adopted BOT Report 6-I-08 that amended AMA policy to specify a minimum of 100 AMA members (from 250) and twenty-five % (from thirty five percent) of its physicians asAMA members.</td>
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</tr>
<tr>
<td>Aerospace Medical Association (1977)</td>
<td>I-08: Have a grace period of one year to bring themselves into compliance.</td>
<td></td>
</tr>
<tr>
<td>American Society of Addiction Medicine (1988)</td>
<td>I-08: Have a grace period of one year to bring themselves into compliance.</td>
<td></td>
</tr>
<tr>
<td>American Association for Hand Surgery (2003)</td>
<td>A-08: BOT report noted noncompliance and recommended a grace period of one year (Referred)</td>
<td>I-08: Representation continued (compliant with new membership threshold)</td>
</tr>
<tr>
<td>American Clinical Neurophysiology Society (1998)</td>
<td>A-08: BOT report noted noncompliance and recommended a grace period of one year (Referred)</td>
<td>I-08: Representation continued (compliant with new membership threshold)</td>
</tr>
<tr>
<td>American Society of Ophthalamic Plastic &amp; Reconstructive Surgery (1998)</td>
<td>A-08: BOT report noted noncompliance and recommended a grace period of one year (Referred)</td>
<td>I-08: Representation continued (compliant with new membership threshold)</td>
</tr>
<tr>
<td>American Academy of Allergy, Asthma and Immunology (1977)</td>
<td>I-08: Noncompliance noted as well as a one-year grace period, but the House voted to continue representation.</td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American College of Nuclear Medicine (1979)</td>
<td>I-09: Did not submit information as it is in the process of merging with the College of Nuclear Physicians. The HOD voted to give it a one-year grace period to bring itself into compliance or be removed from the HOD.</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Geriatrics Society (1978) [Admitted as American Geriatric Society]</td>
<td>I-10: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
<td>I-11: Representation continued (compliant).</td>
</tr>
<tr>
<td>Organization</td>
<td>I-10:</td>
<td>I-11:</td>
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<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>American College of Occupational and Environmental Medicine (1977)</td>
<td></td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td><strong>2011</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMDA—Society for Post-Acute and Long-Term Care Medicine (1991)</td>
<td>A-11:</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td>[Admitted as American Medical Directors Association]</td>
<td>A-12:</td>
<td>Representation retained (noncompliant).</td>
</tr>
<tr>
<td>American Pediatric Surgical Association (1986)</td>
<td>A-11:</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td></td>
<td>A-12:</td>
<td>Representation discontinued (did not submit materials and thus determined to be noncompliant; APSA notified they would no longer be participating).</td>
</tr>
<tr>
<td>American Society of Bariatric Physicians (2001)</td>
<td>A-11:</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td></td>
<td>A-12:</td>
<td>Representation retained (noncompliant).</td>
</tr>
<tr>
<td>American Society of Neuroradiology (1996)</td>
<td>A-11:</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td></td>
<td>A-12:</td>
<td>Representation retained (compliant).</td>
</tr>
<tr>
<td>Korean–American Medical Association (2006)</td>
<td>A-11:</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td></td>
<td>A-12:</td>
<td>Representation discontinued (did not submit materials and thus determined to be noncompliant).</td>
</tr>
<tr>
<td>Renal Physicians Association (1986)</td>
<td>A-11:</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td></td>
<td>A-12:</td>
<td>Representation retained (noncompliant).</td>
</tr>
<tr>
<td>Society of Interventional Radiology (1991)</td>
<td>A-11:</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td></td>
<td>A-12:</td>
<td>Representation retained (compliant).</td>
</tr>
<tr>
<td>American Society of Radiation Oncology (1978)</td>
<td></td>
<td>I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
</tr>
<tr>
<td>[Admitted as the American Society for Therapeutic Radiologists, later renamed ASTRO, American Society for Therapeutic Radiology and Oncology]</td>
<td></td>
<td>I-12: Representation continued (noncompliant).</td>
</tr>
<tr>
<td>Organization</td>
<td>I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
<td>I-12: Representation continued (noncompliant).</td>
</tr>
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<td>-------------------------------------------------------------------------------</td>
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<td>---------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>American Society of Cytopathology (1982) [Admitted as American Society of Cytology]</td>
<td>I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
<td>I-12: Representation continued (noncompliant).</td>
</tr>
<tr>
<td>Society for Vascular Surgery (1996) [Admitted as International Society for Cardiovascular Surgery]</td>
<td>I-11: Given a grace period of one year to meet the membership requirements to retain position in AMA HOD.</td>
<td>I-12: Representation continued (noncompliant).</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Society of Nuclear Medicine and Molecular Imaging (1979) [Admitted as Society of Nuclear Medicine]</td>
<td>I-12: Reported as noncompliant. Representation continued (noncompliant).</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Society of Hematology (1989)</td>
<td>A-14: Given a grace period of one year to meet the membership requirements to retain position in the AMA HOD.</td>
<td>A-15: Given a grace period of one year to meet the membership requirements to retain position in the AMA HOD.</td>
</tr>
<tr>
<td>American College of Physician Executives (1989)</td>
<td>A-14: Representation terminated at the organization’s request.</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>I-14:</td>
<td>I-15:</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>American College of Chest Physicians (1977)</td>
<td>Given six months to submit materials for consideration for continued representation or risk loss of representation.</td>
<td>Representation retained (compliant).</td>
</tr>
<tr>
<td>National Association of Medical Examiners (1983)</td>
<td>Given a grace period of one year to meet the membership requirements to retain position in the AMA HOD.</td>
<td>Representation continued (compliant).</td>
</tr>
<tr>
<td>Society of Medical Consultants to the Armed Forces (1978)</td>
<td>Representation terminated per the organization’s request (sunset as an organization).</td>
<td></td>
</tr>
<tr>
<td><strong>2015</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Rhythm Society (2010)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2016</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Association of Clinical Endocrinologists (1996)</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
<td>Representation continued (compliant).</td>
</tr>
<tr>
<td>American Association of Hip and Knee Surgeons (2001)</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
<td>Representation discontinued (noncompliant).</td>
</tr>
<tr>
<td>American Society of Neuroimaging (1989)</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
<td>Representation discontinued (noncompliant).</td>
</tr>
<tr>
<td>Society of Interventional Radiology (1991)</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
<td>Representation continued (compliant).</td>
</tr>
<tr>
<td>American Academy of Sleep Medicine (1996) [Admitted as American Sleep Disorders Association]</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
<td></td>
</tr>
<tr>
<td>American Society of Cytopathology (1982) [Admitted as American Society of Cytology]</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
<td></td>
</tr>
<tr>
<td>Organization</td>
<td>Decision</td>
<td>Action</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
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<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>American Society of Plastic Surgeons (1977)</td>
<td>I-16:</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
</tr>
<tr>
<td>[Admitted as American Society of Plastic and Reconstructive Surgeons]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>A-17:</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
</tr>
<tr>
<td>Academy of Physicians in Clinical Research (2002)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[Admitted as American Academy of Pharmaceutical Physicians, later known as American Academy of Pharmaceutical Physicians and Investigators]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Society of General Surgeons (1997)</td>
<td>A-17:</td>
<td>Placed on probation and given one year to work with AMA membership staff to increase their AMA membership.</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

To fulfill their ethical responsibility of competence, physicians at all stages in their professional lives should cultivate and exercise skills of self-awareness and active self-observation; take advantage of tools for self-assessment that are appropriate to their practice settings and patient populations; and be attentive to environmental and other factors that may compromise their ability to bring their best skills to the care of individual patients. As a profession, medicine should provide meaningful opportunity for physicians to hone their ability to be self-reflective.
The expectation that physicians will provide competent care is central to medicine. This expectation shaped the founding mission of the American Medical Association (AMA) and runs throughout the AMA Code of Medical Ethics [1-4]. It undergirds professional autonomy and the privilege of self-regulation granted to medicine by society [5]. The profession promises that practitioners will have the knowledge, skills, and characteristics to practice safely and that the profession as a whole and its individual members will hold themselves accountable to identify and address lapses [6-9].

Yet despite the centrality of competence to professionalism, the Code has not hitherto examined what the commitment to competence means as an ethical responsibility for individual physicians in day-to-day practice. This report by the Council on Ethical and Judicial Affairs explores this topic to develop ethics guidance for physicians.

DEFINING COMPETENCE

A caveat is in order. Various bodies in medicine undertake point-in-time, cross-sectional assessments of physicians’ technical knowledge and skills. However, this report is not concerned with matters of technical proficiency assessed by medical schools and residency programs, specialty boards (for purposes of certification), or hospital and other health care organizations (e.g., for privileging and credentialing). Such matters lie outside the Council’s purview.

The ethical responsibility of competence encompasses more than knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Importantly, the ethical responsibility of competence requires that physicians at all stages of their professional lives be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole. For purposes of this analysis, competence is understood as “the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served” and as “developmental, impermanent, and context dependent” [10].

Moreover, the Council is keenly aware that technical proficiency evolves over time—what is expected of physicians just entering practice is not exactly the same as what is expected of mid-
career physicians or physicians who are changing or re-entering practice or transitioning out of active practice to other roles. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues.

The concept that informs this report differs as well from the narrower legal definition of competence as the knowledge and skills an individual has to do a job. Rather, this report explores a broader notion of competence that encompasses deeper aspects of wisdom, judgment and practice that enable physicians to assure patients, the public, and the profession that they provide safe, high quality care moment to moment over the course of a professional lifetime.

SELF-ASSESSMENT & ITS LIMITATIONS

Health care institutions and the medical profession as a whole take responsibility to regulate physicians through credentialing and privileging, routinely testing knowledge (maintenance of certification, requirements for continuing education, etc.) and, when needed, taking disciplinary action against physicians who fail to meet expectations for competent, professional practice. However, the better part of the responsibility to maintain competence rests with physicians’ “individual capacity, as clinicians, to self-assess [their] strengths, deficiencies, and learning needs to maintain a level of competence commensurate with [their] clinical roles” [11].

Self-assessment has thus become “integral to many appraisal systems and has been espoused as an important aspect of personal professional behavior by several regulatory bodies and those developing learning outcomes for students” [12]. Undergraduate and graduate medical education programs regularly use self-assessment along with third-party evaluations to ensure that trainees are acquiring the knowledge and skills necessary for competent practice [5, 10, 13-16].

Yet how accurately physicians assess their own performance is open to question. Research to date suggests that there is poor correlation between how physicians rate themselves and how others rate them [5, 12, 13]. Various studies among health professionals have concluded that clinicians and trainees tend to assess their peers’ performance more accurately than they do their own; several have found that poor performers (e.g., those in the bottom quartile) tend to over-estimate their abilities while high performers (e.g., those in the top quartile), tend to under-estimate themselves [5, 12, 17].

The available findings suggest that self-assessment involves an interplay of factors that can be complicated by lack of insight or of metacognitive skill, that is, ability to be self-observant in the moment. Similarly, personal characteristics (e.g., gender, ethnicity, or cultural background) and the impact of external factors (e.g., the purpose of self-assessment or whether it is designed to assess practical skills or theoretical knowledge) can all affect self-assessment [12, 18]. The published literature also indicates that interventions intended to enhance self-assessment may seek different goals—improving the accuracy of self-assessors’ perceptions of their learning needs, promoting appropriate change in learning activities, or improving clinical practice or patient outcomes [12].

Self-assessment alone is not a reliable enough tool to ensure that physicians acquire and maintain the competence they need to provide safe, high quality care. Feedback from third parties is essential—or as one researcher has observed, “The road to self-knowledge may run through other people” [19]. However, physicians are often wary of assessment. They have indicated that while they want feedback, they are not sure how to use information that is not congruent with their self-appraisals [20]. Physicians can be hesitant to seek feedback for fear of looking incompetent or exposing possible deficiencies or out of concern that soliciting feedback could adversely affect
their relationships with those whom they approach [20]. They may also question the accuracy and
credibility of the assessment process and the data it generates [21].

To be effective, feedback must be valued both by those being assessed and by those offering
assessment [14]. When there is tension between the stated goals of assessment and the implicit
culture of the health care organization or institution, assessment programs can too readily devolve
into an activity undertaken primarily to satisfy administrators that rarely improves patient care [20].
Feedback mechanisms should be appropriate to the skills being assessed—multi-source reviews
(“360° reviews”), for example, are generally better suited to providing feedback on communication
and interpersonal skills than on technical knowledge or skills—and easy for evaluators to
understand and use [14]. High quality feedback will come from multiple sources; be specific and
focus on key elements of the ability being assessed; address behaviors rather than personality or
personal characteristics; and “provide both positive comments to reinforce good behavior and
constructive comments with action items to address deficiencies” [22]. Beyond such formal
mechanisms, physicians should welcome and seek out informal input from colleagues. They should
be willing to offer timely comments to colleagues as well.

EXPERTISE & EXPERT JUDGMENT

On this broad understanding of competence, physicians’ thought processes are as important as their
knowledge base or technical skills. Thus, understanding competence requires understanding
something of the nature of expertise and processes of expert reasoning, themselves topics of
ongoing exploration [23, 24, 25, 26]. Prevailing theory distinguishes “fast” from “slow” thinking;
that is, reflexive, intuitive processes that require minimal cognitive resources versus deliberate,
algorithmic processes that require more conscious effort [25]. Some scholars take expertise to
involve “fast” processes, and specifically decision making that involves automatic, nonanalytic
resources acquired through experience [23]. Others argue that expertise consists in using “slow,”
effortful, analytic processes to address problems [23]. A more integrative view argues that
expertise resides in being able to transition between intuitive and analytical processes as
circumstances require. On this account, experts use automatic resources to free up cognitive
capacity so that they maintain awareness of the environment (“situational awareness”) and can
determine when to shift to effortful processes [23].

Expert judgment is the ability “to respond effectively in the moment to the limits of [one’s]
automatic resources and to transition appropriately to a greater reliance on effortful processes when
needed” [23], a practice described as “slowing down.” Knowing when to slow down and be
reflective has been demonstrated to improve diagnostic accuracy and other outcomes [25]. To
respond to the unexpected events that often arise in a clinical situation, the physician must
“vigorously monitor relevant environmental cues” and use these as signals to slow down, to
transition into a more effortful state [24]. This can happen, for example, when a surgeon confronts
an unexpected tumor or anatomical anomaly during a procedure. “Slowing down when you should”
serves as a critical marker for intraoperative surgical judgment [23].

INFLUENCES ON CLINICAL REASONING

Clinical reasoning is a complex endeavor. Physicians’ capabilities develop through education,
training, and experiences that provide tools with which to shape their clinical reasoning. Every
physician arrives at a diagnosis and treatment plan for an individual in ways that may align with or
differ from the analytical and investigative processes of their colleagues in innumerable ways.
When something goes wrong in the clinic, it can be difficult to discern why. Nonetheless, all
physicians are open to certain common pitfalls in reasoning, including relying unduly on heuristics and habits of perception, and succumbing to overconfidence.

**Heuristics**

Physicians often use various heuristics—i.e., cognitive short cuts—to aid decision making. While heuristics can be useful tools to help physicians identify and categorize relevant information, these time-saving devices can also derail decision making. For example, a physician may mistakenly assume that “something that seems similar to other things in a certain category is itself a member of that category” (the representative heuristic) [27], and fail to diagnose a serious health problem. Imagine a case in which a patient presents with symptoms of a possible heart attack or a stroke that the physician proceeds to discount as stress or intoxication once the physician learns that the patient is going through a divorce or smells alcohol on the patient’s breath. Or a physician may miscalculate the likelihood of a disease or injury occurring by placing too much weight “on examples of things that come to mind easily, . . . because they are easily remembered or recently encountered” (the availability heuristic) [27]. For example, amidst heavy media coverage of an outbreak of highly infectious disease thousands of miles away in a remote part of the world, a physician seeing a patient with symptoms of what is actually a more commonplace illness may misdiagnose (or over diagnose) the exotic condition because that is what is top of mind.

Clinical reasoning can be derailed by other common cognitive missteps as well. These can include misperceiving a coincidental relationship as a causal relationship (illusory bias), or the tendency to remember information transferred at the beginning (or end) of an exchange but not information transferred in the middle (primary or recency bias) [25, 27, 29].

**Habits of Perception**

Like every other person, physicians can also find themselves prone to explicit (conscious) or implicit (unconscious) habits of perception or biases. Physicians may allow unquestioned assumptions based on a patient’s race or ethnicity, gender, socioeconomic status, or health behavior, among other features, to shape how they perceive the patient and how they engage with, evaluate and treat the individual. Basing one’s interactions with a patient on pre-existing expectations or stereotypes demeans the patient, undermines the patient’s relationship with the physician and the health care system, and can result in significant health disparities across entire communities [30]. This is of particular concern for patients who are members of minority and historically disadvantaged populations [30]. Physicians may fall victim to the tendency to seek out information that confirms established expectations or dismiss contradicting information that does not fit into predetermined beliefs (confirmatory bias) [27]. These often inadvertent thought processes can result in a physician pursuing an incorrect line of questioning or testing that then leads to a misdiagnosis or the wrong treatment.

No matter how well a patient may seem to fit a stereotype, it is imperative that the physician look beyond categories and assumptions to investigate openly the health issues experienced by the patient. Although all human beings exhibit both conscious and unconscious habits of perception, physicians must remain vigilant in not allowing preconceived or unexamined assumptions to influence their medical practice.

**Overconfidence**

Finally, another obstacle to strong clinical reasoning that physicians may encounter is overconfidence. Despite their extensive training, physicians, like all people, are poor at identifying
the gaps in their knowledge [27, 29]. Physicians may consider their skills to be excellent, when, in fact, their peers have identified areas for improvement [29]. Overconfidence in one’s abilities can lead to suboptimal care for a patient, be it through mismanaging resources, failing to consider the advice of others, or not acknowledging one’s limits [27, 29].

To avoid falling into such traps, physicians must recognize that many factors can and will influence their clinical decisions [27]. They need to be aware of the information they do and do not have and they need to acknowledge that many factors can and will influence their judgment. They should keep in mind the likelihood of diseases and conditions and take the time to distinguish information that is truly essential to sound clinical judgment from the wealth of possibly relevant information available about a patient. They should consider reasons their decisions may be wrong and seek alternatives, as well as seek to disprove rather than confirm their hypotheses [27]. And they should be sensitive to the ways in which assumptions may color their reasoning and not allow expectations to govern their interactions with patients.

Shortcomings can be an opportunity for growth in medicine, as in any other field. By becoming aware of areas in which their skills are not at their strongest and seeking additional education or consulting with colleagues, physicians can enhance their practice and best serve their patients.

FROM SELF-ASSESSMENT TO SELF-AWARENESS

Recognizing that many factors affect clinical reasoning and that self-assessment as traditionally conceived has significant shortcomings, several scholars have argued that a different understanding of self-assessment is needed, along with a different conceptualization of its role in a self-regulating profession [31]. Self-assessment, it is suggested, is a mechanism for identifying both one’s weaknesses and one’s strengths. One should be aware of one’s weaknesses in order to self-limit practice in areas in which one has limited competence, to help set appropriate learning goals, and to identify areas that “should be accepted as forever outside one’s scope of competent practice” [31]. Knowing one’s strengths, meanwhile, allows a physician both to “act with appropriate confidence” and to “set appropriately challenging learning goals” that push the boundaries of the physician’s knowledge [31].

If self-assessment is to fulfill these functions, physicians need to reflect on past performance to evaluate not only their general abilities but also specific completed performances. At the same time, they must use self-assessment predictively to assess how likely they are to be able to manage new challenges and new situations. More important, physicians should understand self-assessment as an ongoing process of monitoring tasks during performance [32]. The ability to monitor oneself in the moment is critical to physicians’ ethical responsibility to practice safely, at the top of their expertise but not beyond it.

Expert practitioners rely on pattern recognition and other automatic resources to be able to think and act intuitively. As noted above, an important component of expert judgment is transitioning effectively from automatic modes of thinking to more effortful modes as the situation requires. Self-awareness, in the form of attentive self-observation (metacognitive monitoring), alerts physicians when they need to direct additional cognitive resources to the immediate task. For example, among surgeons, knowing when to “slow down” during a procedure is critical to competent professional performance, whether that means actually stopping the procedure, withdrawing attention from the surrounding environment to focus more intently on the task at hand, or removing distractions from the operating environment [24].
Physicians should also be sensitive to the ways that interruptions and distractions, which are common in health care settings, can affect competence in the moment [33, 34], by disrupting memory processes, particularly the “prospective memory”—i.e., “a memory performance in which a person must recall an intention or plan in the future without an agent telling them to do so”—important for resuming interrupted tasks [34, 35]. Systems-level interventions have been shown to help reduce the number or type of interruptions and distractions and mitigate their impact on medical errors [36].

A key aspect of competence is demonstrating situation-specific awareness in the moment of being at the boundaries of one’s knowledge and responding accordingly [32]. Slowing down, looking things up, consulting a colleague, or deferring from taking on a case can all be appropriate responses when physicians’ self-awareness tells them they are at the limits of their abilities. The capacity for ongoing, attentive self-observation, for “mindful” practice, is an essential marker of competence broadly understood:

Safe practice in a health professional’s day-to-day performance requires an awareness of when one lacks the specific knowledge or skill to make a good decision regarding a particular patient . . . . This decision making in context is importantly different from being able to accurately rate one’s own strengths and weaknesses in an acontextual manner. . . . Safe practice requires that self-assessment be conceptualized as repeatedly enacted, situationally relevant assessments of self-efficacy and ongoing ‘reflection-in-practice,’ addressing emergent problems and continuously monitoring one’s ability to effectively solve the current problem [31].

Self-aware physicians discern when they are no longer comfortable handling a particular type of case and know when they need to obtain more information or need additional resources to supplement their own skills [31]. Self-aware physicians are also alert to how external stressors—the death of a loved one or other family crisis, or the reorganization of their practice, for example—may be affecting their ability to provide care appropriately at a given time. They recognize when they should ask themselves whether they should postpone care, arrange to have a colleague provide care, or otherwise find ways to protect the patient’s well-being.

MAINTAINING COMPETENCE ACROSS A PRACTICE LIFETIME

For physicians, the ideal is not simply to be “good” practitioners, but to excel throughout their professional careers. This ideal holds not just over the course of a sustained clinical practice, but equally when physicians re-enter practice after a hiatus, transition from active patient care to roles as educators or administrators, or take on other functions in health care. Self-assessment and self-awareness are central to achieving that goal.

A variety of strategies are available to physicians to support effective self-assessment and help physicians cultivate the kind of self-awareness that enables them to “know when to slow down” in day-to-day practice. One such strategy might be to create a portfolio of materials for reflection in the form of written descriptions, audio or video recording, or photos of encounters with patients that can provide evidence of learning, achievement and accomplishment [16] or of opportunities to improve practice. A strength of portfolios as a tool for assessing one’s practice is that, unlike standardized examinations, they are drawn from one’s actual work and require self-reflection [15].

As noted above, to be effective, self-assessment must be joined with input from others. Well-designed multi-source feedback can be useful in this regard, particularly for providing information about interpersonal behaviors [14]. Research has shown that a four-domain tool with a simple response that elicits feedback about how well one maintains trust and professional relationships
with patients, one’s communication and teamwork skills, and accessibility offers a valid, reliable tool that can have practical value in helping to correct poor behavior and, just as important, consolidate good behavior [14]. Informal arrangements among colleagues to provide thoughtful feedback will not have the rigor of a validated tool but can accomplish similar ends.

Reflective practice, that is, the habit of using critical reflection to learn from experience, is essential to developing and maintaining competence across a physician’s practice lifetime [37]. It enables physicians to “integrate personal beliefs, attitudes, and values in the context of professional culture,” and to bridge new and existing knowledge. Studies suggest that reflective thinking can be assessed, and that it can be developed, but also that the habit can be lost over time with increasing years in practice [37].

“Mindful practice,” that is, being fully present in everyday experience and aware of one’s own mental processes (including those that cloud decision making) [38], sustains the attitudes and skills that are central to self-awareness. Medical training, with its fatigue, dogmatism, and emphasis on behavior over consciousness, erects barriers to mindful practice, while an individual’s unexamined negative emotions, failure of imagination, and literal-mindedness can do likewise. Mindfulness can be self-taught, but for most it is most effectively learned in relationship with a mentor or guide. Nonetheless, despite challenges, there are myriad ways physicians can cultivate mindfulness. Meditation, which may come first to mind, is one, but so is keeping a journal, reviewing videos of encounters with patients, or seeking insight from critical incident reports [38].

“Exemplary physicians,” one scholar notes, “seem to have a capacity for self-critical reflection that pervades all aspects of practice, including being present with the patient, solving problems, eliciting and transmitting information, making evidence-based decisions, performing technical skills, and defining their own values” [38].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed:

The expectation that physicians will provide competent care is central to medicine. It undergirds professional autonomy and the privilege of self-regulation granted by society. To this end, medical schools, residency and fellowship programs, specialty boards, and other health care organizations regularly assess physicians’ technical knowledge and skills. However, as an ethical responsibility competence encompasses more than medical knowledge and skill. It requires physicians to understand that as a practical matter in the care of actual patients, competence is fluid and dependent on context. Each phase of a medical career, from medical school through retirement, carries its own implications for what a physician should know and be able to do to practice safely and to maintain effective relationships with patients and with colleagues. Physicians at all stages of their professional lives need to be able to recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole.

To fulfill the ethical responsibility of competence, individual physicians and physicians in training should:

(a) Exercise continuous self-awareness and self-observation;
(b) Recognize that different points of transition in professional life can make different demands on competence;

(c) Take advantage of well-designed tools for self-assessment appropriate to their practice settings and patient populations;

(d) Seek feedback from peers and others;

(e) Be attentive to environmental and other factors that may compromise their ability to bring appropriate skills to the care of individual patients and act in the patient’s best interest. Medicine as a profession should continue to refine mechanisms for assessing knowledge and skill and should develop meaningful opportunities for physicians and physicians in training to hone their ability to be self-reflective and attentive in the moment.

(New HOD/CEJA Policy)

Fiscal Note: Less than $500.
REFERENCES


Subject: Mergers of Secular and Religiously Affiliated Health Care Institutions

Presented by: Dennis S. Agliano, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Edmund R. Donoghue, Jr, MD, Chair)

Policy D-140.956 “Religiously Affiliated Medical Facilities and the Impact on a Physician's Ability to Provide Patient Centered, Safe Care Services,” asks that the American Medical Association (AMA):

conduct a study of access to care in secular hospitals and religiously-affiliated hospitals to include any impact on access to services of consolidation in secular hospital systems and religiously-affiliated hospital systems.

The resolution on which this directive is based discussed the conflicts present in decision-making for health care professionals employed by religiously affiliated institutions. Given that the presence of religiously affiliated hospitals continues to grow, the resolution encouraged our AMA to conduct a study of access to care in secular hospitals and religiously affiliated hospitals to include any impact on access to services in the consolidation of systems.

RELIGIOUSLY AFFILIATED HEALTH CARE INSTITUTIONS

The concept of the hospital as a facility providing inpatient care for the sick originated with the Catholic Church, with the original and enduring dual mission of healing the body and promoting spiritual well-being [1]. The mission of today’s Catholic Health Association remains focused on the needs of those who are “poor, underserved, and most vulnerable” [2]. Although hospitals established by Protestant denominations and Jewish-identified facilities remain important segments of U.S. health care, Catholic facilities predominate among religiously affiliated institutions—U.S. Catholic Health Care is the largest nonprofit care provider in the country [2].

Since the 1990s, mergers between secular and religiously affiliated hospitals and health care institutions have been reshaping the landscape of health care in the United States, for both patients and physicians. Driven by economic considerations and changes in health policy, notably in recent years, emphasis on accountable care organizations and bundled payments [1,3], mergers have enabled facilities in some cases simply to survive and in others to thrive within their communities. Consolidation has enabled hospitals to control a greater share of their local markets and to negotiate effectively with insurers [4].

Religiously affiliated hospitals and facilities benefit from the tax-exempt status of the religious institutions they represent and from other tax subsidies that derive from their mission to serve the poor and provide charitable care [5]. Although the majority of religiously affiliated hospitals remain nonprofit, the number of for-profit hospitals affiliated with religious institutions increased by 22 percent between 2001 and 2016 [6]. Religiously affiliated health care facilities—which

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encompass clinics, hospitals, and long-term care facilities—are also important employers. According to the Catholic Health Association, as of 2017 member facilities employed more than 500,000 full-time and 200,000 part time staff [2].

In some communities, religiously affiliated health care institutions may be the only providers [6]—as of 2015, 132 of the nation’s approximately 1,300 critical access hospitals were members of U.S. Catholic Health Care [2]. In some areas, more than 40 percent of short-term, acute care beds are in Catholic facilities [6]. Nationwide, one in every six patients now receives care in a Catholic hospital [2].

THE DILEMMA OF MERGERS

The consolidation of a religiously affiliated institution with a secular health care facility raises challenges for all stakeholders—the facilities, their communities, their patients, and the physicians and other professionals who provide care. All religiously affiliated institutions seek to remain faithful to their defining mission and values, which can place them in tension with their secular counterparts. Catholic facilities, however, are embroiled in an increasingly public debate about the implications and effects of entering into arrangements with secular institutions as they seek to retain their identity and mission and still survive in the health care marketplace. Thus they offer a window through which to understand the ethical dimension of health care mergers.

As the Ethical and Religious Directives that govern care in Catholic health care facilities observe:

New partnerships can be opportunities to realign the local delivery system in order to provide a continuum of health care to the community; they can witness to a responsible stewardship of limited health care resources; and they can be opportunities to provide to poor and vulnerable persons a more equitable access to basic care.

On the other hand, new partnerships can pose serious challenges to the viability of the identity of Catholic health care institutions and services, and their ability to implement these Directives in a consistent way, especially when partnerships are formed with those who do not share Catholic moral principles (§VI)[7].

From this perspective, in the contemporary health care marketplace Catholic hospitals “are caught in an impossible bind” [1]. Like other hospitals, financial pressures drive them to consolidate with other institutions to become more economically efficient. Yet “competing in the aggressive world of the medical business industry” can put Catholic hospitals’ historical commitment to the poor at risk [1]. At the same time, gaining financial security may risk “imperceptibly compromising their traditional Catholic witness” when compromises are made with respect to Directives [1].

From the perspective of those they serve, a merger or consolidation may help guarantee the continued presence of health care in a community, but may also limit the range of services available to patients when the consolidated entity adheres to the Directives. Certain treatment choices for care at the end of life, reproductive health care services, and, by some reports, certain services for transgender individuals may all be affected [4, 8, 9]. Limitations on women’s health services have been a focus of concern for obstetricians and gynecologists associated with or employed by religiously affiliated hospitals [10], with reports of conflict over both elective and clinically indicated surgical sterilization [11, 12], and management of miscarriage [13]. Restricted access to services can have a disproportionate impact on poor women, and women in rural areas where religiously affiliated institutions are the only providers of care [14].
From the perspective of physicians and other health care professionals affiliated with or employed by the entity that results, a merger can challenge professional commitments. A merger that results in loss of access to services for the community and requires physicians to follow the religious guidelines embodied in the Directives may result in “conflict with prevailing medical standards of care and ethical principles of health care professional” [15]. Physicians and other health care professionals who are not members of the faith tradition may find themselves contractually prohibited from providing care that is otherwise legal and, in their professional judgment, clinically appropriate and ethically permissible under the norms of medical professionalism.

THE RESPONSIBILITIES OF LEADERSHIP

As challenging as mergers between secular and religiously affiliated health care facilities may be for individual patients and physicians, addressing dilemmas of mission is pre-eminently a responsibility of hospital leadership.

For Catholic facilities merging with secular facilities (or facilities associated with other religious traditions), a touchstone is the principle of cooperation [16, 17]. The principle, it is argued, is a necessity for business relationships in a pluralistic world, providing a way to address the reality that, for the faithful, “it is almost impossible to bring about good without brushing up against or even becoming somewhat involved in the wrongdoing of others” [16]. The principle of cooperation is understood “as a limiting principle, to avoid cooperating in evil” (original emphasis) [17].

The essential goal is to ensure that institutional arrangements allow the facility and its staff to “remain as removed as possible” from violations of the directives and “not to contribute anything essential to make possible the wrongdoing’s occurring” [16]—e.g., essential employed staff or equipment for the performance of what under the Directives is an immoral procedure [17]. Whether services that would be otherwise prohibited by the Directives will or may be available through the merged entity is importantly a function of how caregiving is organized in the resulting composite system. The approval of the diocesan bishop is required for mergers involving facilities subject to his governing authority, and the diocesan bishop has final authority for assessing whether a proposed merger constitutes morally licit cooperation (§VI) [7].

Analogous discussions of the ethics of trusteeship, such as that offered by The Hastings Center, offer secular insight for thinking about the responsibilities of leaders in health care institutions. Trustees of not-for-profit health care organizations “regularly make decisions that affect the lives and well-being of a large number of people who are relatively powerless, relatively vulnerable, and in need of services or assistance” [18]. In light of the mission of such organizations, service on a board of trustees entails fiduciary duties to the organization and responsibility to ensure that the organization realizes the public benefits for which it enjoys tax exempt status.

Trustees are held to principles of fidelity to mission; service to patients, ensuring that the care is high quality and provided “in an effective and ethically appropriate manner”; service to the community the hospital serves, deploying hospital resources “in ways that enhance the health and quality of life” of the community; and institutional stewardship. They have a further responsibility to ensure that when there is conflict over fundamental values and principles, “all points of view are heard and taken seriously, that reasonable compromise is explored, and that consensus has time to form” [18].

The Principles of Integrated Leadership for Hospitals and Health Care Systems, developed in collaboration by the American Hospital Association (AHA) and the AMA, address responsibilities of hospital leadership in the context of rapidly evolving models of integrated physician-hospital
health care systems [19]. In addition to governance and management structure and leadership
development, guidance identifies “cultural adaptation” as a key element for success, observing that:

Culture is the way an organization, institution or integrated health system does business, in a
way that is predictable, known to all and consonant with the mission and values of the
organization, institution or integrated health system. The creation of a common shared culture
that includes an integrated set of values is important to serve as a guide to the entity and will
serve as a touch point to help resolve the inevitable conflicts that will arise [19].

The AHA-AMA principles urge integrated health systems to cultivate the characteristics of
adaptive institutional culture, including a focus on the health of the entire population served;
agreement to a common mission, vision, and values; mutual understanding and respect; and a sense
of common ownership of the entity and its reputation [19].

INSIGHT FROM THE CODE OF MEDICAL ETHICS

As frontline clinicians, physicians (and other health care professionals) regularly confront the
effects on patients’ lives and well-being of the institutional arrangements through which care is
delivered. They have a responsibility to advocate for the resources patients need, as well as to be
responsible stewards of the resources with which they are entrusted [20]. They must be able to
make treatment recommendations in keeping with their best judgment as medical professionals
[21]. And they are expected to uphold the ethical norms of medicine, including fidelity to patients
and respect for patients as moral agents and decision makers [22].

Existing guidance on exercise of conscience by individual physicians suggests essential
responsibilities of leadership in health care as well [22]. These include responsibility to engage in
thoughtful consideration of the implications of institutional arrangements—whether arrangements
sustain or risk undermining the personal and professional integrity of staff, cause moral distress, or
compromise the ability to provide care. Leaders in health care institutions must be mindful that
arrangements do not discriminate against or unduly burden individual patients or populations of
patients, and of the burden arrangements may place on fellow professionals. And they must accept
responsibility to take steps to ensure that services will be available to meet the needs of the patients
and community the institution serves.

RECOMMENDATIONS

In light of this analysis, the Council on Ethical and Judicial Affairs recommends:

1. That Policy D-140.956, “Religiously Affiliated Medical Facilities and the Impact on a
Physician's Ability to Provide Patient Centered, Safe Care Services,” be rescinded. (Rescind
HOD Policy)

2. That the following be adopted, and the remainder of this report be filed:

The merger of secular health care institutions and those affiliated with a faith tradition can
benefit patients and communities by sustaining the ability to provide a continuum of care
locally in the face of financial and other pressures. Yet consolidation among health care
institutions with diverging value commitments and missions may also result in limiting what
services are available. Consolidation can be a source of tension for the physicians and other
health care professionals who are employed by or affiliated with the consolidated health care
entity.
Protecting the community that the institution serves as well as the integrity of the institution, the physicians and other professionals who practice in association with it, is an essential, but challenging responsibility.

Physician-leaders within institutions that have or are contemplating a merger should:

(a) Seek input from stakeholders to inform decisions to help ensure that after a consolidation the range of services previously offered will continue to be available to the community.

(b) Be transparent about the values and mission that will guide the consolidated entity and proactively communicate to stakeholders, including prospective patients, physicians, staff, and civic leaders, how this will affect patient care and access to services.

(c) Negotiate contractual issues of governance, management, financing, and personnel that will respect the diversity of values within the community and at minimum that the same range of services remains available in the community.

(d) Recognize that physicians’ primary obligation is to their patients. Physician-leaders in consolidated health systems should provide avenues for meaningful appeal and advocacy to enable associated physicians to respond to the unique needs of individual patients.

(e) Establish mechanisms to monitor the effect of new institutional arrangements on patient care and well-being and the opportunity of participating clinicians to uphold professional norms, both to identify and address adverse consequences and to identify and disseminate positive outcomes.

Individual physicians associated with institutions that have consolidated or propose to consolidate should:

(f) Work to hold leaders accountable to meeting conditions for professionalism within the institution.

(g) Advocate for solutions when there is ongoing disagreement about services or arrangements for care.

(New HOD/CEJA Policy)

Fiscal note: Less than $500
REFERENCES

Subject: Senior Physicians Section Five-Year Review

Presented by: Glenn Loomis, MD, Chair

Referred to: Reference Committee F
(Julia V. Johnson, MD, Chair)

AMA Bylaw 7.0.9 states, “A delineated section must reconfirm its qualifications for continued
delineated section status and associated representation in the House of Delegates by demonstrating
at least every 5 years that it continues to meet the criteria adopted by the House of Delegates.”
AMA Bylaw 6.6.1.5 states that one function of the Council on Long Range Planning and
Development (CLRPD) is “to evaluate and make recommendations to the House of Delegates,
through the Board of Trustees, with respect to the formation and/or change in status of any section.
The Council will apply criteria adopted by the House of Delegates.”

The Council analyzed information from the letter of application submitted by the Senior Physicians
Section (SPS) for renewal of delineated section status.

APPLICATION OF CRITERIA TO THE SENIOR PHYSICIANS SECTION

Criterion 1: Issue of Concern - Focus will relate to concerns that are distinctive to the subset within
the broader, general issues that face medicine. A demonstrated need exists to deal with these
matters, as they are not currently being addressed through an existing AMA group.

When the SPS was established at the 2012 Interim Meeting of the House of Delegates (HOD), the
Section identified an array of concerns affecting the landscape of medicine, particularly among
physicians age 65 and older. Among the issues identified were decisions on retirement or reducing
work capacity; competency evaluation; state licensing and licensure laws, particularly with regard
to physician reentry to medicine or volunteering; transitions in payment models, technology,
regulations and organizational structures; strategies to engage senior physicians in community
leadership for the purposes of advocacy and engagement with the AMA’s strategic focus areas;
health and wellness programs; and mentoring roles. Prior to the establishment of the SPS, the
interests of senior physicians were represented as a special group, which served an advisory role to
the Board of Trustees (BOT) from 2006-2012.

CLRPD assessment: The mission of the SPS is to provide a dedicated forum within the AMA to
increase discussion of and advocacy on senior physician issues and strengthen the AMA’s ability to
represent this physician constituency. The SPS provides advice and counsel to the Association on
policy and program issues of interest to senior physicians, and offers suggestions for activities that
best meet the needs of this physician segment. There are currently no other groups or sections
within the AMA that specifically address the unique issues of concern of senior physicians. The
SPS provides a formal structure for senior physicians to participate directly in the deliberations of
the HOD and impact policy.
Criterion 2: Consistency - Objectives and activities of the group are consistent with those of the AMA. Activities make good use of available resources and are not duplicative.

The primary objectives of the SPS are to provide a formalized structure for representation in the HOD of active and retired AMA members over the age of 65; to review, discuss and draft policy positions; to develop and promote products and services relevant to senior physicians; and to identify the needs of senior physicians and advocate on their behalves.

The SPS meetings typically include educational sessions and discussions on topics relevant to senior physicians, specifically cognitive and emotional aging; health and wellness among physicians; practice patterns, transitioning out of practice and reentry; and roles for senior physicians in medical education. All surveyed participants at the A-16 SPS Meeting said both that the meeting was a valuable use of their time and that they would recommend the meeting to their peers. A survey conducted by the AMA’s Physician Engagement Unit found that a large percentage of retired physicians rely primarily on medical associations and societies for professional support.

The SPS promotes tools that educate physicians as they transition out of full time practice. A July 2016 membership report found the YTD retention rates for senior and retired physicians were 85.1% and 89.6%, respectively.

The SPS collaborates with other sections, AMA units and staff, and councils on issues of shared concern. For the continuing medical education (CME) programs on aging, the SPS partnered with the Council on Science and Public Health, the Organized Medical Staff Section, the Council on Medical Education and the International Medical Graduates Section. In 2016, the SPS collaborated with the Academic Physicians Section on a CME program focused on physician burnout. The SPS develops its strategy with active participation from BOT liaisons, ensuring alignment with AMA priorities. Topics selected for educational programs aim to highlight AMA strategic objectives, such as increasing physician satisfaction, improving safety and quality of medical practice, and continuing education, while collaboration with other groups helps to maximize the efficiency and impact of SPS efforts.

CLRPD Assessment: The SPS serves its constituents by bringing professional issues unique to senior physicians to the forefront of organized medicine, and by providing targeted educational programs and resources for the policymaking process.

Criterion 3: Appropriateness - The structure of the group will be consistent with its objectives and activities.

In 2013, the BOT approved the SPS internal operating procedure (IOP), which designated a seven-member governing council (GC) elected by majority vote of SPS membership to guide the Section’s programs and activities. Modifications to the SPS IOP designated the Immediate Past Chair as an officer position to add continuity to GC leadership, and required candidates for delegate and alternate delegate positions to have previously held local, state, specialty society or national leadership positions, ensuring that those elected possessed the experience required to fulfill those roles. All members of the SPS are eligible for election to any office, aside from the aforementioned requirements for delegate positions. The GC convenes a strategic planning meeting each year, typically facilitated by a BOT liaison, to discuss short- and long-term goals of the SPS, and to outline a specific work agenda and enduring direction for the SPS that meets the needs of senior physicians while supporting the AMA.

The SPS undertakes a collaborative policymaking process leading up to the Section’s meetings that includes involvement/input from individual SPS members. An online member forum affords an
opportunity for SPS members to submit resolution ideas. If AMA policy already exists on a topic, that information is posted to the forum. A virtual SPS meeting allows all SPS members to provide testimony on resolution proposals and reports. A majority vote of those present helps to develop consensus, which guides the actions of the SPS delegate and alternate delegate when submitting items of business to the HOD. At least one liaison from every state participates in the SPS Assembly, a business meeting led by the Section’s delegates and held in conjunction with each HOD meeting, during which liaisons discuss SPS-sponsored resolutions and other HOD business items.

CLRPD Assessment: The SPS convenes a GC from its members and holds strategic planning meetings to plot its annual and long-term goals and ensure alignment with the goals of the AMA. All section members have opportunities throughout the year to contribute to the deliberations of the SPS either in person or by virtual means.

Criterion 4: Representation Threshold - Members of the formal group would be based on identifiable segments of the physician population and AMA membership. The formal group would be a clearly identifiable segment of AMA membership and the general physician population. A substantial number of members would be represented by this formal group. At minimum, this group would be able to represent 1,000 AMA members.

Membership in the SPS is determined by age; all AMA member physicians age 65 and older are members of the SPS, making the segment of the population represented by the SPS easily identifiable. Year-end figures from 2016 indicated that 54,738 members of the AMA were age 65 or older, representing 22.8% of all AMA members. Of all physicians and medical students, 305,181 were age 65 and older, 17.9% of which were AMA members in 2016.

CLRPD Assessment: The SPS is comprised of members from an identifiable segment of AMA membership and the general physician population, and the Section represents a substantial number of members. AMA Physician Masterfile data indicate that the number of physicians age 65 and over has grown steadily for more than a decade, highlighting the alignment of SPS with potential AMA membership growth.

Criterion 5: Stability - The group has a demonstrated history of continuity. This segment can demonstrate an ongoing and viable group of physicians will be represented by this section and both the segment and the AMA will benefit from an increased voice within the policymaking body. During the 2016 Annual Meeting of the HOD, approximately 60 physicians attended the SPS Assembly, and about 100 attended the subsequent educational session. Typically, SPS educational programs feature nationally recognized speakers, provide actionable insights for senior physicians’ clinical, professional and personal needs, and are highly rated by attendees. Figures from the SPS GC elections indicate increasing engagement. In 2014, the inaugural SPS GC election, 709 votes were cast in the first election and 751 were cast in the runoff; in 2016, 1,259 were cast in the first election and 1,580 were cast in the runoff. Approximately 14,000 physicians have opted in to receive monthly emails on the activities of the SPS.

Governance management of the SPS has for the past three years aligned strategically with the AMA Physician Engagement Unit to leverage the knowledge of SPS members to identify the needs of the senior physician population, and provide products, services and targeted communications to grow engagement with the Section and the AMA, positioning the SPS for further growth. The number of physicians age 65 and over has grown consistently for more than a decade, increasing the potential for future growth of the SPS.
In 2014, the HOD adopted an SPS resolution requesting a study to determine the need for professional regulation in assuring quality and safety of patients cared for by older physicians. SPS leadership collaborated with the Council on Medical Education to explore whether competency tools existed. HOD adoption of the Council on Medical Education’s recommendations (CME Report 5-A-15) resulted in AMA Policy D-275.956, “Assuring Safe and Effective Care for Patients by Senior/Late Career Physicians.” Subsequently, the AMA assembled a workgroup comprised of a large number of national experts from multiple disciplines who study aging to establish principles for determining competence—an effort to avert a call for mandatory retirement age or the imposition of guidelines by others. The Council on Medical Education plans to submit a follow up report in 2018. In 2016, the outcome of this work resulted in the publication of a peer-reviewed paper on the status of senior physician competency authored by Richard Hawkins, MD, the AMA’s VP of Medical Education Programs, and four additional authors, including Paul Wick, MD, an SPS GC member. The report suggests the implementation of a screening process based on evidence-based guidelines and consistent quality standards to determine competency, rather than age-specific retirement mandates and other restrictions.

The SPS delegates have provided testimony to the HOD on items relevant to both senior physicians and the broader AMA, including access to self-administered medications, repeal of anti-kickback safe harbor for group purchasing organizations and guidelines for prescribing opioids. The SPS sends a monthly newsletter to all senior physicians who opt in, which contains a timeline of activities leading up to HOD meetings, and information on how to submit resolutions, post to online forums and attend virtual reference committees. Biannually, the SPS convenes a virtual meeting to maintain open communication among all Section members and allow members to discuss submitted resolutions or testify on items relevant to senior physicians. The SPS uses resolution idea forms and resolution templates to ease the process of introducing resolution topics.

During the Section’s 2016 Interim Meeting, the GC outlined broad areas of focus that adhere to the mission of the SPS, including practice patterns and transitioning out of practice, the roles of senior physicians in supplementing and filling gaps in community health needs, and overcoming barriers to adopting and implementing technology. Meetings of the SPS Assembly are largely spent reviewing items of interest to the SPS, selected in advance by the SPS delegate and alternate delegate, and formulating SPS positions on reports and resolutions submitted to the HOD.

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As a demographic group, senior physicians are not underrepresented in the HOD. CLRDP Report 2-A-17, Demographic Characteristics of the House of Delegates and AMA Leadership revealed that senior physicians made up 33.8% of all delegates in the HOD—a higher percentage than senior physician AMA members (22.8%) and the proportion of senior physicians that made up the
nationwide population of physicians and medical students (23.8%). However, when serving on state and specialty delegations, senior physicians are obligated to represent the interests of their respective delegations, limiting their opportunities to address issues of concern specific to their demographic group. AMA Policy G-615.002, “AMA Member Component Groups,” states, “Delineated Sections will allow a voice in the house of medicine for large groups of physicians, who are connected through a unique perspective, but may be underrepresented.” The SPS provides the appropriate structure for a focused voice on issues that uniquely affect senior physicians.

RECOMMENDATION

The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Senior Physicians Section through 2022 with the next review no later than the 2022 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500
EXECUTIVE SUMMARY

The catalyst for this report was Resolution 308-I-16, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” from the Medical Student Section, which asked that our American Medical Association (AMA): 1) pursue legislative and/or regulatory avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition amongst medical schools and prevent unnecessary increases in domestically-trained medical student debt; 2) support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and 3) reaffirm policies D-295.320, D-295.931, and D-295.937. Due to the complexity of the issues surrounding this topic, the resolution was referred.

This report considers concerns that have been raised about the availability of clinical clerkship training sites due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in the absolute numbers of U.S. medical schools—as well as the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions. These schools, which cater primarily to U.S. citizen international medical graduates (USIMGs), are generally located in the Caribbean, and are sometimes referred to as “offshore medical schools.” The educational experience of U.S. medical students could be compromised through competition with other learners for faculty attention and access to patients.

This report comprises:
• A review of state efforts to address this issue, in New York and Texas
• A summary of relevant medical school accreditation standards
• An analysis of potential implications for the physician workforce
• Consideration of legal and antitrust issues around this issue
• A review of past Council on Medical Education reports and AMA policy on this topic
• Proposed emendations to current AMA policy to strengthen and streamline the AMA’s position on this important topic

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REPORT OF THE COUNCIL ON MEDICAL EDUCATION

CME Report 1-I-17

Subject: Promoting and Reaffirming Domestic Medical School Clerkship Education
(Resolution 308-I-16)

Presented by: Lynne Kirk, MD, Chair

Referred to: Reference Committee K
(L. Samuel Wann, MD, Chair)

GENESIS AND OUTLINE

Resolution 308-I-16, “Promoting and Reaffirming Domestic Medical School Clerkship Education,” introduced by the Medical Student Section, asked that the American Medical Association (AMA): 1) pursue legislative and/or regulatory avenues that promote the regulation of the financial compensation which medical schools can provide for clerkship positions in order to facilitate fair competition among medical schools and prevent unnecessary increases in domestically-trained medical student debt; 2) support the expansion of partnerships of foreign medical schools with hospitals in regions which lack local medical schools in order to maximize the cumulative clerkship experience for all students; and 3) reaffirm policies D-295.320, D-295.931, and D-295.937.

Testimony at Reference Committee C during the 2016 Interim Meeting was unanimous in support of referral of Resolution 308. This is a complex issue, with numerous factors, ranging from state law to physician workforce implications. It was felt that a thorough analysis by the Council on Medical Education was required to ensure an in-depth, nuanced solution to this issue—one that involves all key stakeholders and places patient care and education needs at the forefront. Accordingly, Resolution 308-I-16 was referred.

This report comprises:

- A review of state efforts to address this issue, in New York and Texas.
- A summary of relevant medical school accreditation standards.
- An analysis of potential implications for the physician workforce.
- Consideration of legal and antitrust issues around this issue.
- A review of past Council on Medical Education reports and AMA policy on this topic.

BACKGROUND

Clinical clerkships are required of medical school programs accredited by the Liaison Committee on Medical Education (LCME). These clerkships are conducted, at least in part, within teaching hospitals with which the medical school has an affiliation or formal agreement for instruction of its students. The clinical phase of education traditionally takes place in years three and four in LCME-accredited medical schools.

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Concerns have been raised about the availability of clinical clerkship training sites due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical schools and in the absolute numbers of U.S. medical schools, as well as competition for placement sites from other health professions programs, such as nurse practitioner and physician assistant programs. Further, the extensive and ongoing consolidation in the health care industry has led to closure of multiple hospital facilities, with concomitant reduction in the number of sites available for clinical education. The educational experience of U.S. medical students could be compromised through competition with other learners for faculty attention and access to patients.

A final factor (which is most pertinent to this report) is the growing number of foreign medical schools that seek to place their students in clerkships in U.S. institutions—in particular, those schools that cater primarily to U.S. citizen international medical graduates (USIMGs). Many of these institutions are located in the Caribbean, and are sometimes referred to as “offshore medical schools.” The eight largest of these institutions (by number of students certified by the Educational Commission for Foreign Medical Graduates [ECFMG] in 2013) include:

- St George’s University School of Medicine (Grenada) 891
- Ross University School of Medicine (Dominica) 815
- American University of Antigua College of Medicine (Antigua and Barbuda) 347
- American University of the Caribbean (Sint Maarten) 281
- Saba University School of Medicine (Saba) 156
- Windsor University School of Medicine (Saint Kitts and Nevis) 139
- Medical University of the Americas (Saint Kitts and Nevis) 135
- Saint Matthew’s University (Cayman Islands) 129

(Note: A full list is available in Appendix A, as adapted from Eckhert NL, van Zanten M. Overview of For-Profit Schools in the Caribbean. 2014. Foundation for Advancement of International Medical Education and Research.)

Accreditation/approval of these institutions is the purview of a variety of bodies, each with varying standards and requirements for quality of education. These include seeking recognition through the Ministry of Education or Ministry of Health of the institution’s home country, or accreditation or approval from regional agencies, such as the Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP) and the Accreditation Commission on Colleges of Medicine, (a nonprofit organization in Ireland that inspects and accredits medical schools in countries that do not have a national medical accreditation body). As of 2023, the ECFMG will require that physicians applying for ECFMG Certification graduate from a medical school that has been “appropriately accredited”—that is, “accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME) or that uses other globally accepted criteria, such as those put forth by the World Federation for Medical Education (WFME).”

Offshore medical schools typically do not own teaching hospitals. It is common for these students to complete their required clinical clerkships in another country, and the level of supervision and instruction provided to the medical student can vary widely. Medical students attending these schools tend to complete their required clinical clerkships in the U.S. Offshore medical schools are often willing to provide significant financial remuneration to secure slots for their students’ clerkship experiences. These funds are often an attractive source of revenue, particularly for urban hospitals/institutions in underserved areas.
In theory, U.S. medical schools could provide similar financial incentives to gain access to clinical sites or faculty. However, the cost would most likely be passed on to students in the same way such costs are covered for students who are attending offshore medical schools. This could result in raised tuition, and ultimately increase U.S. medical student debt (as noted in Resolve 1 of Resolution 308-I-16).

The buying (and selling) of clerkship slots benefits the offshore medical student seeking a clerkship as well as the offshore medical school and the stateside institution providing the clerkship. Medical schools (and medical students) in the United States, however, may be negatively affected. Data compiled from the 2012-2013 LCME Annual Medical Questionnaire (Part II) showed that, of the 136 medical school programs accredited at that time, 52.2 percent (71) saw increased difficulty in finding inpatient clinical placements for students in core clerkships. Of these schools, 25 attributed this increased difficulty in part to “competition for placement sites from offshore international medical schools” (along with other factors, including increase in class size and other U.S. schools in the region). Of the 15 states with the highest number of schools reporting such issues, 12 are in the northeast and mid-Atlantic regions and the upper Midwest.

STATE REGULATIONS

Nine states evaluate the physician’s clinical clerkships in connection with an application for licensure. In most states, clerkships for U.S. medical students must take place in hospitals affiliated with medical schools accredited by the LCME or with residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). A number of states have special rules that apply to students of non-LCME-accredited medical schools in the Caribbean.

New York

Since 1981, the New York State Board of Regents has had in place regulations on the eligibility of students enrolled in offshore medical schools for clinical clerkships in New York hospitals. In summary, only students from offshore medical schools that have been approved by the New York State Education Department are eligible to complete clinical clerkships totaling more than 12 weeks in New York teaching hospitals. In addition, students wishing to participate in such clerkships must pass the United States Medical Licensing Examination (USMLE) Step 1 examination, and the clerkship may only occur in a teaching hospital with which the offshore medical school has an approved affiliation agreement. In addition, the teaching hospital must have a residency program accredited by the ACGME in the clerkship discipline.

The approval process for offshore medical schools, handled by the New York State Education Department, is based on an assessment of educational quality similar to a medical school accreditation review. Students from medical schools that are unapproved by the department are limited to no more than 12 weeks’ clerkship experience in New York teaching hospitals.

In 2008, New York City Health and Hospitals Corporation signed a 10-year, $10 million exclusive contract with a state-approved offshore medical school, through which the school pays $400 per student per week for training slots. Several other such schools soon entered into similar agreements with other New York institutions, and a 2009 report subsequently found that “about half of the 4,000 medical students doing third- and fourth-year rotations in New York State were from offshore medical schools.” These agreements began to raise concern among U.S.-based educators as to the availability of clerkships for their own students, as well as concerns that accreditation standing might be jeopardized if the quality of clerkship experiences was negatively affected due to the sheer number of students in a given rotation.
One challenge in evaluating these concerns is that the literature is silent with respect to the appropriate number of medical students in a clerkship or the resources needed to assure that a rotation is “adequate,” and indeed, the “adequate” number of students may change based on patient population and geographic location. To attempt to better ascertain these data, the Association of Medical Schools of New York (AMSNY) fielded a survey of clerkship directors in 2009. A second iteration of that survey is scheduled soon. The survey, which included questions on the availability of an adequate number of faculty/residents/staff and patients, as well as physical and IT resources, concluded that:

- LCME and COCA standards control the educational behaviors of accredited schools, but have no influence on hospitals seeking to enhance revenue streams through the sale of clerkship “slots” to unaccredited bidders.
- The establishment of quantitative benchmarks may help schools in negotiations with their traditional academic affiliates.
- Legislative action may be needed to assure quality training and patient safety in state- or federal-regulated care delivery-sites.

Texas

In April 2013, the Texas legislature passed legislation to address growing concerns that affiliation agreements between offshore medical schools and Texas hospitals and other health care facilities would limit Texas medical students’ options for clinical training. Through the enacted legislation, the following subsection was added to the state’s Education Code:

(c) The board may not issue a certificate of authority for a private postsecondary institution to grant a professional degree or to represent that credits earned in this state are applicable toward a degree if the institution is chartered in a foreign country or has its principal office or primary educational program in a foreign country. In this subsection, “professional degree” includes a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Veterinary Medicine (D.V.M.), Juris Doctor (J.D.), and Bachelor of Laws (LL.B.)

The legislation was supported by the Texas Medical Association (TMA) and the state’s medical schools, which feared a diminution in the number of clinical clerkships for its medical students, due in part to the willingness of offshore medical schools to pay for clerkships for their students. With only one exception, Texas medical schools do not pay for clerkships and are in no position financially to do so. Had the state legislation not been passed, it would have been expected that Texas medical schools would not have been able to afford to compete in paying for clerkships, thereby displacing Texas medical students from long-standing clerkships at Texas teaching hospitals. As a result, medical schools would likely have been forced to participate in bidding wars for clerkship space, and, consequently, pass on this added cost to medical students, resulting in increased tuition and likely, increased student debt. Noted one of the co-authors of the Texas legislation, “Our Texas medical students should be prioritized, and we must ensure they have access to those clinical rotations without doing anything to jeopardize that. They are our investment. [The state] invests in medical education, and we have to protect that investment.”

The TMA’s advocacy on this issue was buttressed by policy adopted in 2013, which resulted from a report of the association’s Council on Medical Education (see Appendix B). The policy stated, in part, that the TMA “strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, our association strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities that lack sufficient educational resources for the
supervised teaching of clinical medicine.” In addition, the policy states, “2. Institutions that accept students for clinical placements should ensure that all such students are trained in programs that meet requirements for curriculum, clinical experiences, and attending supervision as expected for [LCME- and COCA-accredited] programs.… 3. TMA opposes extraordinary payments by any medical school for access to clinical rotations. 4. Foreign medical students should not displace Texas medical students in clinical training positions at Texas health care facilities. Priority should be given to Texas medical students and other health care professionals for clinical training.”

RELEVANT LCME STANDARDS

A number of LCME standards are relevant to the topic of this report, including:

4.1 Sufficiency of Faculty
A medical school has in place a sufficient cohort of faculty members with the qualifications and time required to deliver the medical curriculum and to meet the other needs and fulfill the other missions of the institution.

5.5 Resources for Clinical Instruction
A medical school has, or is assured the use of, appropriate resources for the clinical instruction of its medical students in ambulatory and inpatient settings and has adequate numbers and types of patients (e.g., acuity, case mix, age, gender).

5.10 Resources Used by Transfer/Visiting Students
The resources used by a medical school to accommodate any visiting and transfer medical students in its medical education program do not significantly diminish the resources available to already enrolled medical students.

10.8 Visiting Students
A medical school does all of the following:
• Verifies the credentials of each visiting medical student
• Ensures that each visiting medical student demonstrates qualifications comparable to those of the medical students he or she would join in educational experiences
• Maintains a complete roster of visiting medical students
• Approves each visiting medical student’s assignments
• Provides a performance assessment for each visiting medical student
• Establishes health-related protocols for such visiting medical students
• Identifies the administrative office that fulfills these responsibilities

LCME requirements also provide guidance as to faculty serving as supervisors for medical students from more than one institution. For example, a 2014 LCME white paper notes the following, in part:

4. A given medical school must evaluate the quality of its education across sites, including at the site(s) that serve(s) students from multiple schools, and must ensure and document that comparability exists in the curricular core, including in required clinical encounters.

5. There must be sufficient patient resources and faculty numbers so that medical students from each medical education program are able to meet their defined objectives and required clinical encounters and have appropriate levels of supervision and assessment.
The presence of students from another school must not diminish the access to resources needed by students from a given medical school to meet the objectives of the specific course/clerkship, including appropriate patients/procedures and faculty.

6. If two or more LCME-accredited medical schools share faculty at a given instructional site, there should be coordination between the schools, for example, an agreement that each medical school will have appropriate access to needed resources to support its medical education program.

Resources include: 1) faculty with sufficient time to teach each cohort of students and to participate in relevant faculty development, 2) patients sufficient to meet the required clinical conditions specified by each medical school, and 3) appropriate facilities for the total numbers of students at the site at any given time.

LIMITATIONS ON AMA ACTIONS

The types of actions that the AMA can take are limited by antitrust considerations. That is, the AMA as a private entity cannot act in concert with others to limit competition by attempting to deny or restrict access of medical students from offshore medical schools to U.S. teaching hospitals. The AMA can, however, advocate to governmental entities for such limitations as a means to assure the ongoing quality of the U.S. medical education system. The AMA can also develop model state legislation that would reflect best practices for financial remuneration of clerkships.

PAST COUNCIL ON MEDICAL EDUCATION REPORTS AND RELEVANT AMA POLICY

The availability of clerkships for medical students has been the topic of three recent Council on Medical Education reports:


As a result of these and other reports and resolutions, the AMA has a number of policies on this topic:

3. H-295.995 (30, 31), “Recommendations for Future Directions for Medical Education”
4. D-295.320, “Factors Affecting the Availability of Clinical Training Sites for Medical Student Education”
5. D-295.931, “Update on the Availability of Clinical Training Sites for Medical Student Education”

This report includes recommendations for revisions to consolidate and streamline these policies, as shown in Appendix C.
DISCUSSION

The issue of adequate availability of clerkships for U.S. medical students can be seen in the context of larger issues—in particular, the quality and quantity of the future physician workforce. That workforce comprises both U.S. medical school graduates as well as a significant number of IMGs (both U.S. citizens and noncitizens). To clarify thinking in this regard, several questions may be posed. For example, is the quality of education/training for U.S. medical students imperiled by competition for clerkships by students from offshore medical schools? Also, are USIMGs receiving an adequate education to prepare them for residency and practice in the U.S.?

Recent literature on this topic urges increased scrutiny of offshore medical schools and their graduates. Eckhert writes, “Just as the Flexner Report strengthened medical education by raising standards, recommending quality improvements, and suggesting closure of weaker schools, a present-day review of the schools [in other countries] whose purpose is to train physicians for the United States could lead to recommendations for improvement and/or accreditation, educational innovations, or sanctions against poorly performing medical schools.” She argues that the U.S. must “look beyond our borders to ensure that physicians around the world obtain the best possible education. To begin this effort close to home—in the Caribbean Basin—makes good sense, because the growing number of graduates from the [offshore medical schools] there will be part of the next generation of physicians caring for the U.S. public and practicing alongside U.S.-trained physicians.”

Likewise, note Halperin and Goldberg, “U.S. medical education today faces a threat similar to that leading up to the Flexner Report, although this time the schools that do not meet the training standards necessary to ensure public health are outside U.S. borders. A dire emergency is approaching that could compromise American medical education.” They call for a number of potential solutions; most pertinent to this report, these include that state higher education boards deny students of proprietary offshore schools access to clinical education in U.S. teaching hospitals unless these schools meet accreditation standards equivalent to those expected of U.S. medical schools.” In addition, they urge additional legislation at the state level, similar to that passed in Texas in 2013, described above.

Related to the second question posed above, the educational standards of offshore medical schools are a topic of some concern—particularly as students at these institutions are able to obtain federal funding. Attrition (and tuition) rates are high, and educational resources often lack in comparison to those at LCME-accredited medical school programs. Norcini et al. raised concerns about “striking” gaps in clinical performance among practicing USIMGs versus their non-citizen IMG and U.S. medical school graduate counterparts, and proposed further research “to clarify whether [USIMG] performance is a result of their medical education experiences or their ability. To the degree that it is the former, U.S. citizens will need information about international medical schools on which to base their application decisions. To the degree that it is the latter, and as additional training opportunities become available for U.S. citizens, medical schools and residency programs will need to be more vigilant in their selection procedures and not accept students who lack the ability to perform as physicians.”

As to the resolve clauses of Resolution 308-I-16, the AMA can pursue or support legislative and regulatory advocacy to promote fair competition amongst medical schools vying for clerkship positions. Additionally, the AMA can focus on educational quality, to include the appropriate number of students on a given clerkship at any one time, and address such educational aspects as curriculum, supervision, and procedural experience (logbooks). The AMA can work with interested
state and specialty medical associations to pursue legislation that addresses this issue and helps ensure a quality experience for all medical students.

Related to Resolve 2 of Resolution 308-I-16, fostering partnerships with hospitals that are not currently used for clinical teaching may benefit both students from offshore schools as well as U.S. students; this possibility also aligns with AMA policy on addressing geographic disparities in access to care. In fact, it may be appropriate that clerkship training slots be treated as public resources to help expand the physician workforce—particularly in underserved areas—versus being seen as the “property” of academic medical centers and teaching hospitals.

Finally, Resolve 3, which asks for reaffirmation of AMA policy, is obviated through the recommendations below, which incorporate changes to consolidate and streamline existing policy.

RECOMMENDATIONS

The Council on Medical Education recommends that the following recommendations be adopted in lieu of Resolution 308-I-16, and the remainder of the report be filed.

1. That our American Medical Association (AMA):

   1) Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support: a) infrastructure and faculty development and capacity for medical school expansion; and b) delivery of clinical clerkships and other educational experiences. (Directive to Take Action)

   2) Encourage clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students. (Directive to Take Action)

   3) Advocate for federal and state legislation/regulations to:

      a. Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA);

      b. Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and

      c. Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality, curriculum, clinical experiences and attending supervision that are equivalent to those of programs accredited by the LCME and COCA. (Directive to Take Action)

   4) Encourage relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so,
advocate for the development of appropriate regulations at the state level. (Directive to Take Action)

5) Work with interested state and specialty medical associations to pursue legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students. (Directive to Take Action)

2. Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution’s own students educationally and/or financially and negatively affect the quality of the educational program and/or safety of patients receiving care at these sites. (New HOD Policy)

3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas. (New HOD Policy)

4. U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME or COCA. (New HOD Policy)

5. Existing requirements for foreign medical schools seeking Title IV Funding should be applied to those schools that are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. (New HOD Policy)

6. That Policies H-255.988 (6, 23, 25), H-255.998, H-295.995 (30, 31), D-295.320, D-295.931, and D-295.937 be rescinded, as described in Appendix C to this report. (Rescind HOD Policy)

Fiscal Note: $1,000 for staff time
## APPENDIX A: OFFSHORE MEDICAL SCHOOLS IN 2013, BY NUMBER OF ECFMG-CERTIFIED STUDENTS/GRADUATES

<table>
<thead>
<tr>
<th>School</th>
<th>Location</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>St George’s University School of Medicine</td>
<td>Grenada</td>
<td>891</td>
</tr>
<tr>
<td>Ross University School of Medicine</td>
<td>Dominica</td>
<td>815</td>
</tr>
<tr>
<td>American University of Antigua College of Medicine</td>
<td>Antigua and Barbuda</td>
<td>347</td>
</tr>
<tr>
<td>American University of the Caribbean</td>
<td>Sint Maarten</td>
<td>281</td>
</tr>
<tr>
<td>Saba University School of Medicine</td>
<td>Saba (Special Municipality of the Netherlands)</td>
<td>156</td>
</tr>
<tr>
<td>Windsor University School of Medicine</td>
<td>Saint Kitts and Nevis</td>
<td>139</td>
</tr>
<tr>
<td>Medical University of the Americas</td>
<td>Saint Kitts and Nevis</td>
<td>135</td>
</tr>
<tr>
<td>Saint Matthew’s University</td>
<td>Cayman Islands</td>
<td>129</td>
</tr>
<tr>
<td>American University of Integrative Sciences</td>
<td>Sint Maarten</td>
<td>86</td>
</tr>
<tr>
<td>University of Medicine and Health Sciences</td>
<td>Saint Kitts and Nevis</td>
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</tr>
<tr>
<td>Saint James School of Medicine</td>
<td>Saint Vincent and the Grenadines</td>
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<tr>
<td>Xavier University School of Medicine</td>
<td>Aruba</td>
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<tr>
<td>Avalon University School of Medicine</td>
<td>Curacao</td>
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</tr>
<tr>
<td>Spartan Health Sciences University</td>
<td>Saint Lucia</td>
<td>23</td>
</tr>
<tr>
<td>Trinity School of Medicine</td>
<td>Saint Vincent and the Grenadines</td>
<td>16</td>
</tr>
<tr>
<td>Aureus University School of Medicine</td>
<td>Aruba</td>
<td>12</td>
</tr>
<tr>
<td>23 additional institutions</td>
<td>varies</td>
<td>Fewer than 10</td>
</tr>
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APPENDIX B: REPORT 3-A-12 OF THE TEXAS MEDICAL ASSOCIATION COUNCIL ON MEDICAL EDUCATION

Subject: Clinical Training Resources for Texas Medical Students
Presented by: Cynthia A. Jumper, MD, Chair
Referred to: Reference Committee on Public Health, Science, and Education

A medical school in the Caribbean is seeking to establish affiliation agreements with Texas hospitals and other health care facilities to provide clinical training for its third- and fourth-year medical students to complete their core clinical clerkships in Texas. Our council has grave concerns about the potential damaging effects of a proposal that has the risk of displacing Texas medical students from the already limited clinical training capacity in our state. Our educational institutions already have commitments to Texas students to provide reasonable access to training opportunities. Diminishing our own students’ access to clinical training in the state would negatively affect the quality and affordability of education for Texas medical students, resident physicians, and other health professionals — all who need and deserve priority access to clinical training in the state.

Economic Impact

State support for educating medical students, resident physicians, and other health professionals was severely reduced in the 2012-13 state budget. At the same time, in response to increasing physician demand, Texas medical schools plan an increase of 30 percent in enrollments by 2015. This will result in an estimated total of 3,300 third- and fourth-year medical students each year — the highest numbers ever for our state. There is also a strong potential for a new four-year medical school in South Texas. This vigorous growth in enrollments clearly dictates a need for more hospital clinical training space for our own students in the very near future.

Adding foreign medical students simultaneously with the large Texas enrollment growth will only exacerbate the shortage of clinical training space. The limited supply could result in a considerable increase in the cost of clerkships for medical schools, as is occurring in northeastern states, that could force increases in medical school tuition and related student debt as well as the displacement of our own medical students, and threaten the accreditation status of our own schools.

Benefit to the State

Recognizing that the state has only limited training capacity and the potential financial impact on Texas medical schools and students, thoughtful consideration must be given to the potential benefit to the state. Texas ranks second in the nation, behind California, in the retention of our medical school graduates in the state, at 59 percent.¹

In contrast, it is not known how many students enrolled in foreign medical schools would even have an interest in practicing in Texas. Substituting foreign students for Texas medical students would not benefit the state’s escalating physician workforce needs. It makes little sense for the state to invest at least $170,000 per year for each Texas medical student yet not provide for their reasonable access to core clinical clerkships in the state.

Further, as reported by the American Medical Association Medical Student Section in November 2011,
U.S. medical school accreditation standards require both a broad and significant portfolio of undergraduate experiences as well as a rigorous and specifically defined standard of preclinical education in the first two years of medical school before admitted, visiting, or transfer American medical students are allowed to participate in third year clerkships, yet for-profit offshore medical schools do not provide any standardized or equivalent system of evaluation before they participate in third year clerkships in American hospitals.

**Availability of Clinical Faculty and Student Supervision Rules**

Given the increases in our own medical school enrollment, it is unclear whether there are sufficient numbers of qualified clinical faculty to oversee the training of our own medical students in addition to foreign medical students. The Texas Medical Board has regulations that delineate specific requirements for physicians eligible to supervise medical students.¹ The board’s rules also must be considered to ensure that medical students who complete clerkships in Texas would ultimately be eligible for medical licensure in the state.

**Policy Proposals**

Our council believes it is in the best interest of the state … for quality, education, workforce, as well as economic considerations … to ensure that Texas medical school students are provided first access to core clinical clerkships in the state. The council proposes adoption of the following principles as Texas Medical Association policy, including relevant policies of AMA, with their adaptation for Texas.

1. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the Texas Medical Association strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, our association strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities that lack sufficient educational resources for the supervised teaching of clinical medicine.

2. Institutions that accept students for clinical placements should ensure that all such students are trained in programs that meet requirements for curriculum, clinical experiences, and attending supervision as expected for programs accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation.

3. The Texas Medical Association opposes extraordinary payments by any medical school for access to clinical rotations.

4. Foreign medical students should not displace Texas medical students in clinical training positions at Texas health care facilities. Priority should be given to Texas medical students and other health care professionals for clinical training.

**Recommendation: Approval as TMA policy.**


ii. Texas Medical Board Program Rule, §162.1. Supervision of Medical Students.

   (a) In order to supervise a medical student who is enrolled at a Texas medical school as a full-time student or visiting student the physician must have an active and unrestricted Texas license.
(b) In order to supervise a medical student who does not meet the criteria in subsection (a) of this section the physician must:

1. have an active and unrestricted Texas license;
2. hold a faculty position in the graduate medical education program in the same specialty in which the student will receive undergraduate medical education;
3. supervise the student during the educational period; and
4. supervise the student’s medical education in either a Texas hospital or teaching institution, which sponsors or participates in a program of graduate medical education accredited by the Accrediting Council for Graduate Medical Education, the American Osteopathic Association, or the Texas Medical Board in the same subject as the medical or osteopathic medical education in which the hospital or teaching institution has an agreement with the applicant’s school.

(c) If the physician is not licensed in Texas as required in subsection (a) or (b) of this section, the physician must be employed by the federal government and maintain an active and unrestricted license.

(d) Physician applicants who receive medical education in the United States in settings that do not comply with statutory requirements set forth in Texas Occupations Code §155.003(b) - (c) may be ineligible for licensure.
APPENDIX C: RECOMMENDED ACTIONS ON HOUSE OF DELEGATES’ POLICIES RELATED TO CLERKSHIPS

H-255.988, “AMA Principles on International Medical Graduates”

_Delete 6, 23, and 25, for incorporation into the proposed new policy. These three items are more relevant to the topic of availability of clinical clerkships than to principles on international medical graduates._

Our AMA supports:

1. Current U.S. visa and immigration requirements applicable to foreign national physicians who are graduates of medical schools other than those in the United States and Canada.
2. Current regulations governing the issuance of exchange visitor visas to foreign national IMGs, including the requirements for successful completion of the USMLE.
3. The AMA reaffirms its policy that the U.S. and Canada medical schools be accredited by a nongovernmental accrediting body.
4. Cooperation in the collection and analysis of information on medical schools in nations other than the U.S. and Canada.
5. Continued cooperation with the ECFMG and other appropriate organizations to disseminate information to prospective and current students in foreign medical schools. An AMA member, who is an IMG, should be appointed regularly as one of the AMA's representatives to the ECFMG Board of Trustees.
6. The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.
7. Working with the Accreditation Council for Graduate Medical Education (ACGME) and the Federation of State Medical Boards (FSMB) to assure that institutions offering accredited residencies, residency program directors, and U.S. licensing authorities do not deviate from established standards when evaluating graduates of foreign medical schools.
8. In cooperation with the ACGME and the FSMB, supports only those modifications in established graduate medical education or licensing standards designed to enhance the quality of medical education and patient care.
9. The AMA continues to support the activities of the ECFMG related to verification of education credentials and testing of IMGs.
10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.
11. That accreditation standards enhance the quality of patient care and medical education and not be used for purposes of regulating physician manpower.
12. That AMA representatives to the ACGME, residency review committees and to the ECFMG should support AMA policy opposing discrimination. Medical school admissions officers and directors of residency programs should select applicants on the basis of merit, without considering status as an IMG or an ethnic name as a negative factor.
13. The requirement that all medical school graduates complete at least one year of graduate medical education in an accredited U.S. program in order to qualify for full and unrestricted licensure.
14. Publicizing existing policy concerning the granting of staff and clinical privileges in hospitals and other health facilities.
15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state,
county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

20. Institutions that sponsor exchange visitor programs in medical education, clinical medicine and public health to tailor programs for the individual visiting scholar that will meet the needs of the scholar, the institution, and the nation to which he will return.

21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

22. U.S. medical schools offering admission with advanced standing, within the capabilities determined by each institution, to international medical students who satisfy the requirements of the institution for matriculation.

23. Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.

24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

25. Our AMA supports the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding.

H-255.998, “Foreign Medical Graduates”

Rescind and incorporate into the proposed new policy.

Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs): Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.


H-295.995, “Recommendations for Future Directions for Medical Education”

Delete 30 and 31, for insertion into the proposed new policy.

Our AMA supports the following recommendations relating to the future directions for medical education:

(1) The medical profession and those responsible for medical education should strengthen the general or broad components of both undergraduate and graduate medical education. All medical students and resident physicians should have general knowledge of the whole field of medicine regardless of their projected choice of specialty.
(2) Schools of medicine should accept the principle and should state in their requirements for admission that a broad cultural education in the arts, humanities, and social sciences, as well as in the biological and physical sciences, is desirable.
(3) Medical schools should make their goals and objectives known to prospective students and premedical counselors in order that applicants may apply to medical schools whose programs are most in accord with their career goals.
(4) Medical schools should state explicitly in publications their admission requirements and the methods they employ in the selection of students.
(5) Medical schools should require their admissions committees to make every effort to determine that the students admitted possess integrity as well as the ability to acquire the knowledge and skills required of a physician.
(6) Although the results of standardized admission testing may be an important predictor of the ability of students to complete courses in the preclinical sciences successfully, medical schools should utilize such tests as only one of several criteria for the selection of students. Continuing review of admission tests is encouraged because the subject content of such examinations has an influence on premedical education and counseling.
(7) Medical schools should improve their liaison with college counselors so that potential medical students can be given early and effective advice. The resources of regional and national organizations can be useful in developing this communication.
(8) Medical schools are chartered for the unique purpose of educating students to become physicians and should not assume obligations that would significantly compromise this purpose.
(9) Medical schools should inform the public that, although they have a unique capability to identify the changing medical needs of society and to propose responses to them, they are only one
of the elements of society that may be involved in responding. Medical schools should continue to identify social problems related to health and should continue to recommend solutions.

(10) Medical school faculties should continue to exercise prudent judgment in adjusting educational programs in response to social change and societal needs.

(11) Faculties should continue to evaluate curricula periodically as a means of insuring that graduates will have the capability to recognize the diverse nature of disease, and the potential to provide preventive and comprehensive medical care. Medical schools, within the framework of their respective institutional goals and regardless of the organizational structure of the faculty, should provide a broad general education in both basic sciences and the art and science of clinical medicine.

(12) The curriculum of a medical school should be designed to provide students with experience in clinical medicine ranging from primary to tertiary care in a variety of inpatient and outpatient settings, such as university hospitals, community hospitals, and other health care facilities. Medical schools should establish standards and apply them to all components of the clinical educational program regardless of where they are conducted. Regular evaluation of the quality of each experience and its contribution to the total program should be conducted.

(13) Faculties of medical schools have the responsibility to evaluate the cognitive abilities of their students. Extramural examinations may be used for this purpose, but never as the sole criterion for promotion or graduation of a student.

(14) As part of the responsibility for granting the MD degree, faculties of medical schools have the obligation to evaluate as thoroughly as possible the non-cognitive abilities of their medical students.

(15) Medical schools and residency programs should continue to recognize that the instruction provided by volunteer and part-time members of the faculty and the use of facilities in which they practice make important contributions to the education of medical students and resident physicians. Development of means by which the volunteer and part-time faculty can express their professional viewpoints regarding the educational environment and curriculum should be encouraged.

(16) Each medical school should establish, or review already established, criteria for the initial appointment, continuation of appointment, and promotion of all categories of faculty. Regular evaluation of the contribution of all faculty members should be conducted in accordance with institutional policy and practice.

(17a) Faculties of medical schools should reevaluate the current elements of their fourth or final year with the intent of increasing the breadth of clinical experience through a more formal structure and improved faculty counseling. An appropriate number of electives or selected options should be included. (17b) Counseling of medical students by faculty and others should be directed toward increasing the breadth of clinical experience. Students should be encouraged to choose experience in disciplines that will not be an integral part of their projected graduate medical education.

(18) Directors of residency programs should not permit medical students to make commitments to a residency program prior to the final year of medical school.

(19) The first year of postdoctoral medical education for all graduates should consist of a broad year of general training. (a) For physicians entering residencies in internal medicine, pediatrics, and general surgery, postdoctoral medical education should include at least four months of training in a specialty or specialties other than the one in which the resident has been appointed. (A residency in family practice provides a broad education in medicine because it includes training in several fields.) (b) For physicians entering residencies in specialties other than internal medicine, pediatrics, general surgery, and family practice, the first postdoctoral year of medical education should be devoted to one of the four above-named specialties or to a program following the general requirements of a transitional year stipulated in the "General Requirements" section of the "Essentials of Accredited Residencies." (c) A program for the transitional year should be planned, designed, administered, conducted, and evaluated as an entity by the sponsoring institution rather than one or more departments. Responsibility for the executive direction of the program should be
assigned to one physician whose responsibility is the administration of the program. Educational programs for a transitional year should be subjected to thorough surveillance by the appropriate accrediting body as a means of assuring that the content, conduct, and internal evaluation of the educational program conform to national standards. The impact of the transitional year should not be deleterious to the educational programs of the specialty disciplines.

(20) The ACGME, individual specialty boards, and respective residency review committees should improve communication with directors of residency programs because of their shared responsibility for programs in graduate medical education.

(21) Specialty boards should be aware of and concerned with the impact that the requirements for certification and the content of the examination have upon the content and structure of graduate medical education. Requirements for certification should not be so specific that they inhibit program directors from exercising judgment and flexibility in the design and operation of their programs.

(22) An essential goal of a specialty board should be to determine that the standards that it has set for certification continue to assure that successful candidates possess the knowledge, skills, and the commitment to upgrade continually the quality of medical care.

(23) Specialty boards should endeavor to develop a consensus concerning the significance of certification by specialty and publicize it so that the purposes and limitations of certification can be clearly understood by the profession and the public.

(24) The importance of certification by specialty boards requires that communication be improved between the specialty boards and the medical profession as a whole, particularly between the boards and their sponsoring, nominating, or constituent organizations and also between the boards and their diplomates.

(25) Specialty boards should consider having members of the public participate in appropriate board activities.

(26) Specialty boards should consider having physicians and other professionals from related disciplines participate in board activities.

(27) The AMA recommends to state licensing authorities that they require individual applicants, to be eligible to be licensed to practice medicine, to possess the degree of Doctor of Medicine or its equivalent from a school or program that meets the standards of the LCME or accredited by the American Osteopathic Association, or to demonstrate as individuals, comparable academic and personal achievements. All applicants for full and unrestricted licensure should provide evidence of the satisfactory completion of at least one year of an accredited program of graduate medical education in the US. Satisfactory completion should be based upon an assessment of the applicant's knowledge, problem-solving ability, and clinical skills in the general field of medicine. The AMA recommends to legislatures and governmental regulatory authorities that they not impose requirements for licensure that are so specific that they restrict the responsibility of medical educators to determine the content of undergraduate and graduate medical education.

(28) The medical profession should continue to encourage participation in continuing medical education related to the physician's professional needs and activities. Efforts to evaluate the effectiveness of such education should be continued.

(29) The medical profession and the public should recognize the difficulties related to an objective and valid assessment of clinical performance. Research efforts to improve existing methods of evaluation and to develop new methods having an acceptable degree of reliability and validity should be supported.

(30) U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various jurisdictions, prerequisites for entry into graduate medical education programs, and other factors that should be considered before deciding to undertake the study of medicine in schools not accredited by the LCME.

(31) Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects
to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine.

(32) Methods currently being used to evaluate the readiness of graduates of foreign medical schools to enter accredited programs in graduate medical education in this country should be critically reviewed and modified as necessary. No graduate of any medical school should be admitted to or continued in a residency program if his or her participation can reasonably be expected to affect adversely the quality of patient care or to jeopardize the quality of the educational experiences of other residents or of students in educational programs within the hospital.

(33) The Educational Commission for Foreign Medical Graduates should be encouraged to study the feasibility of including in its procedures for certification of graduates of foreign medical schools a period of observation adequate for the evaluation of clinical skills and the application of knowledge to clinical problems.

(34) The AMA, in cooperation with others, supports continued efforts to review and define standards for medical education at all levels. The AMA supports continued participation in the evaluation and accreditation of medical education at all levels.

(35) The AMA, when appropriate, supports the use of selected consultants from the public and from the professions for consideration of special issues related to medical education.

(36) The AMA encourages entities that profile physicians to provide them with feedback on their performance and with access to education to assist them in meeting norms of practice; and supports the creation of experiences across the continuum of medical education designed to teach about the process of physician profiling and about the principles of utilization review/quality assurance.

(37) Our AMA encourages the accrediting bodies for MD- and DO-granting medical schools to review, on an ongoing basis, their accreditation standards to assure that they protect the quality and integrity of medical education in the context of the emergence of new models of medical school organization and governance.


D-295.320, “Factors Affecting the Availability of Clinical Training Sites for Medical Student Education”

Rescind and incorporate into the proposed new policy.

1. Our AMA will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion.

2. Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students.

3. Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured.

4. Our AMA will advocate for regulations that would ensure clinical clerkship slots be given first to students of US medical schools that are Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-approved, or schools currently given preliminary accreditation status, provisional accreditation status, or equivalent, from either of the above bodies.
5. Our AMA will advocate for federal and state legislation or regulations to oppose any
extraordinary compensation for clinical clerkship sites by medical schools or other clinical
programs that would result in displacement or otherwise limit the training opportunities of United
States LCME/COCA students in clinical rotations.
1, I-13)

D-295.931, “Update on the Availability of Clinical Training Sites for Medical Student
Education”

Rescind and incorporate into new proposed policy.

1. Our AMA will work with appropriate collaborators to study how to build additional institutional
and faculty capacity in the US for delivering clinical education.
2. Our AMA, in collaboration with interested stakeholders, will:
   (a) study options to require that students from international medical schools who desire to take
clerkships in US hospitals come from medical schools that are approved by an independent
public or private organization, such as the Liaison Committee on Medical Education, using
principles consistent with those used to accredit US medical schools;
   (b) advocate for regulations that will assure that international students taking clinical clerkships
in US medical schools come from approved medical schools that assure educational quality that
promotes patient safety; and
   (c) advocate that any institution that accepts students for clinical placements be required to
assure that all such students are trained in programs that meet requirements for curriculum,
clinical experiences and attending supervision as expected for Liaison Committee on Medical
Education and American Osteopathic Association accredited programs.
3. Our AMA will study whether the “public service community benefit” commitment and corporate
purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for
granting priority access for teaching purposes to medical students from medical schools in their
service area communities and, if so, advocate for the development of appropriate regulations at the
state level.
4. Our AMA opposes any arrangements of US medical schools or their affiliated hospitals that
allow the presence of visiting students to disadvantage their own students educationally or
financially.

D-295.937, “Competition for Clinical Training Sites”

Rescind; this analysis was completed through Council on Medical Education Report 2-I-08,
“Update on Availability of Clinical Training Sites for Medical Student Education.”

Our AMA will, through the Council of Medical Education, conduct an analysis of the adequacy of
clinical training sites to accommodate the increasing number of medical students in the US
accredited medical schools and study the impact of growing pressure, including political and
financial, to accommodate clinical training in US hospitals for US citizen international medical
students.
(Res. 324, A-08)
### APPENDIX D: SUMMARY OF PROPOSED POLICY CHANGES

| Our AMA will work with the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medical Education to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion. D-295.320 (1) | Our American Medical Association (AMA) will:  
1. Work with the Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, and other interested stakeholders to encourage local and state governments and the federal government, as well as private sector philanthropies, to provide additional funding to support infrastructure and faculty development for medical school expansion and delivery of clinical education. (Directive to Take Action) |
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<td>Our AMA will work with appropriate collaborators to study how to build additional institutional and faculty capacity in the US for delivering clinical education. D-295.931 (1)</td>
<td>2. Encourage clinical clerkship sites for medical education (to include medical schools and teaching hospitals) to collaborate with local, state, and regional partners to create additional clinical education sites and resources for students. (Directive to Take Action)</td>
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<td>Our AMA will encourage medical schools and the rest of the medical community within states or geographic regions to engage in collaborative planning to create additional clinical education resources for their students. D-295.320 (2)</td>
<td>3. Advocate for federal and state legislation/regulations to a) Oppose any extraordinary compensation granted to clinical clerkship sites that would displace or otherwise limit the education/training opportunities for medical students in clinical rotations enrolled in medical school programs accredited by the Liaison Committee on Medical Education (LCME) or Commission on Osteopathic College Accreditation (COCA); b) Ensure that priority for clinical clerkship slots be given first to students of LCME- or COCA-accredited medical school programs; and</td>
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<td>(c) Require that any institution that accepts students for clinical placements ensure that all such students are trained in programs that meet requirements for educational quality,</td>
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<td>(c) advocate that any institution that accepts students for clinical placements be required to assure that all such students are trained in programs that meet requirements for</td>
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curriculum, clinical experiences and attending supervision as expected for Liaison Committee on Medical Education and American Osteopathic Association accredited programs. D-295.931 (2)

(b) advocate for regulations that will assure that international students taking clinical clerkships in US medical schools come from approved medical schools that assure educational quality that promotes patient safety D-295.931 (2)

Our AMA will study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. D-295.931 (3)

4. Encourage relevant stakeholders to study whether the “public service community benefit” commitment and corporate purposes of not for profit, tax exempt hospitals impose any legal and/or ethical obligations for granting priority access for teaching purposes to medical students from medical schools in their service area communities and, if so, advocate for the development of appropriate regulations at the state level. (Directive to Take Action)

5. Develop and disseminate to interested states model legislation that ensures the quality and availability of medical student clerkship positions for U.S. medical students. (Directive to Take Action)

Our AMA supports the following principles, based on recommendations of the Ad Hoc Committee on Foreign Medical Graduates (FMGs):

Our AMA supports the practice of U.S. teaching hospitals and foreign medical educational institutions entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. H-255.998

Our AMA supports the practice of U.S. teaching hospitals and foreign medical schools entering into appropriate relationships directed toward providing clinical educational experiences for advanced medical students who have completed the equivalent of U.S. core clinical clerkships. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of medical students in teaching hospitals and other clinical sites that lack appropriate educational resources and experience for supervised teaching of clinical medicine, especially when the presence of visiting students would disadvantage the institution’s own students educationally and/or
| Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the AMA strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine. (31)  

The core clinical curriculum of a foreign medical school should be provided by that school; U.S. hospitals should not provide substitute core clinical experience for students attending a foreign medical school.  
H-255.988 (6)  

Our AMA opposes any arrangements of US medical schools or their affiliated hospitals that allow the presence of visiting students to disadvantage their own students educationally or financially. D-295.931 (4)  

Our AMA will support the expansion of medical education programs only when educational program quality, including access to appropriate clinical teaching resources, can be assured. D-295.320 (3)  

| Providing U.S. students who are considering attendance at an international medical school with information enabling them to assess the difficulties and consequences associated with matriculation in a foreign medical school.  
H-255.988 (23) | 3. Our AMA supports agreements for clerkship rotations, where permissible, for U.S. citizen international medical students between foreign medical schools and teaching hospitals in regions that are medically underserved and/or that lack medical schools and clinical sites for training medical students, to maximize the cumulative clerkship experience for all students and to expose these students to the possibility of medical practice in these areas. (New HOD Policy)  

U.S. citizens should have access to factual information on the requirements for licensure and for reciprocity in the various U.S. medical licensing jurisdictions, prerequisites for entry into graduate medical education programs, and other relevant factors that should be considered before deciding to undertake the study of |
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<th>medicine in schools not accredited by the LCME or COCA. (New HOD Policy)</th>
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<td>Our AMA supports the application of the existing requirements for foreign medical schools seeking Title IV Funding to those schools which are currently exempt from these requirements, thus creating equal standards for all foreign medical schools seeking Title IV Funding. H-255.988 (25)</td>
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<td>2. Our AMA, in collaboration with interested stakeholders, will: (a) study options to require that students from international medical schools who desire to take clerkships in US hospitals come from medical schools that are approved by an independent public or private organization, such as the Liaison Committee on Medical Education, using principles consistent with those used to accredit US medical schools D-295.931 (2)</td>
<td>Note: This is not needed in the new policy; as of 2023, the Educational Commission for Foreign Medical Graduates has announced that physicians applying for ECFMG certification will be required to graduate from a medical school that has been appropriately accredited. To satisfy this requirement, the physician’s medical school must be accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME) or that uses other globally accepted criteria. The World Federation of Medical Education Recognition Programme will allow medical schools accredited by recognized agencies, and their graduates, to meet ECFMG’s accreditation requirement.</td>
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3 Standards and process for the approval of international medical schools to place students in long-term clinical clerkships in New York State. New York Codes, Rules and Regulations. 8 CRR-NY 60.10; NY-CRR. Available at: http://bit.ly/2svy9v8x. Accessed July 7, 2017


EXECUTIVE SUMMARY

The recently issued executive order instituting new limitations on immigration to the United States introduced great uncertainty into the lives of many physicians in training, physician scientists, medical researchers, hospital administrators, and patients. The health care community expressed immediate concern regarding the impacts of the order, especially during a time when physician shortages are predicted and the number of patients with multiple chronic conditions is growing.

Widespread media coverage of the order and multiple court rulings regarding its legality, combined with the overall complexity of existing U.S. visa regulations, have contributed to public confusion regarding this complicated topic and its multiple implications.

This comprehensive review characterizes the orders’ potential impacts on physicians and patients, and seeks to educate physicians so they can appropriately advocate for their patients and their profession. The report explains the content of the executive order; characterizes the reaction from physicians and scientists; reviews visa implications; discusses potential impacts to international research and data sharing; describes institutional staffing and patient access implications; and offers suggestions regarding areas for further study.

The introduction of the order has prompted extensive and very public discussions regarding the physician workforce in multiple venues, all of which provide an excellent opportunity to educate the American people regarding the crucial, life-saving role played in this country by foreign-born physicians. Additional dialogue regarding the importance of collaborative, international research is also valuable and necessary. The Council on Medical Education will continue to follow this issue and report back to the House of Delegates as necessary.
American Medical Association (AMA) Policy D-255.980, “Impact of Immigration Barriers on the Nation’s Health,” was adopted by the AMA House of Delegates (HOD) at its 2017 Annual Meeting. It states the following:

1. Our American Medical Association (AMA) recognizes the valuable contributions and affirms our support of international medical students and international medical graduates and their participation in U.S. medical schools, residency and fellowship training programs and in the practice of medicine.

2. Our AMA will oppose laws and regulations that would broadly deny entry or re-entry to the United States of persons who currently have legal visas, including permanent resident status (green card) and student visas, based on their country of origin and/or religion.

3. Our AMA will oppose policies that would broadly deny issuance of legal visas to persons based on their country of origin and/or religion.

4. Our AMA will advocate for the immediate reinstatement of premium processing of H-1B visas for physicians and trainees to prevent any negative impact on patient care.

5. Our AMA will advocate for the timely processing of visas for all physicians, including residents, fellows, and physicians in independent practice.

6. Our AMA will work with other stakeholders to study the current impact of immigration reform efforts on residency and fellowship programs, physician supply, and timely access of patients to health care throughout the U.S.

7. Our AMA will update the House of Delegates by the 2017 Interim Meeting on the impact of immigration barriers on the physician workforce.

During the HOD meeting, Reference Committee C heard universal support for the timely and salient resolutions that were introduced regarding these topics, which sought to address and rectify the multiple implications of restricting U.S. travel for foreign-born physicians, trainees, and researchers. Testimony also noted that any travel restrictions could negatively affect patient access to care, especially in areas of need. These same implications hold true for patients served by other foreign-born clinicians and trainees employed in this country.

Restricting travel on the basis of country of origin or religion goes against the principles and policy of our AMA, which has worked to enhance physician diversity and to address the quality of care received and experienced by diverse patients and populations. Additionally, many communities, including rural and low-income areas, face challenges attracting physicians to meet their health...
care needs. International medical graduates (IMGs) often fill these openings. Currently, one out of every four physicians practicing in the United States is an IMG. In certain specialties, that number is even higher. These physicians are trained and licensed by the same stringent requirements applied to U.S. medical school graduates. They are more likely to practice in underserved and poor communities, and in primary care and other specialties that face significant workforce shortages.

Concerns related to additional limitations on immigration also have been voiced by the biomedical research community. Restriction of travel can constrain the free flow of ideas and hamper the international cooperation that has historically led to advancements in the delivery of care.

AMA delegates collectively introduced seven related resolutions to the HOD for the 2017 Annual Meeting; an umbrella resolution, which incorporated elements of all seven resolutions, was subsequently adopted. This report addresses Resolves 6 and 7 of that umbrella resolution. The issue of physician immigration also was highlighted by the Council on Medical Education during the Annual Meeting—with support from the Council on Science and Public Health, Academic Physicians Section, International Medical Graduates Section, Integrated Physician Practice Section, and Medical Student Section—through development of an educational session that called attention to and addressed these important concerns.

Individuals eligible for Deferred Action for Childhood Arrivals (DACA) status face related, but not entirely similar, concerns. Council on Medical Education Report 4-A-17, “Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages,” offers a comprehensive review of DACA-eligible individuals, their prospects, and their potential impact on the U.S. workforce. This report was submitted to and adopted by the HOD (see D-350.986), and interested parties are encouraged to review the report and its findings. The Council on Medical Education continues to monitor DACA and will report back to the HOD as needed.

INTRODUCTION

The executive order issued by President Donald J. Trump on January 27, 2017—“Protecting the Nation from Foreign Terrorist Entry into the United States”—introduced great uncertainty into the lives of physicians in training, physician scientists, other medical researchers, and hospital administrators. Many in the health care community expressed immediate concern regarding the impacts of the proposed order on physicians, institutions, researchers, and patients on multiple levels, especially during a time when physician shortages are predicted and the number of patients with multiple chronic conditions is growing.

A recent article published in JAMA effectively frames these legitimate concerns. The article notes, “At least 1 in 4 physicians [in the U.S.] are foreign born. Research demonstrates that foreign-born physicians offer high-quality care, with low mortality rates among their patients. Due to critical health worker shortages, special visas are offered to foreign physicians who practice for 3 years in rural, underserviced communities. More than 13,000 physicians from the 6 Muslim-majority countries with suspended entry practice in the United States, including 9,000 from Iran and 3,500 from Syria. In 2015 alone, 453 foreign nationals from these countries were admitted to residency programs. If this group of physicians were not replaced, given the size of the average primary care patient panel (2,500 patients), the ban could affect more than 1 million patients nationally.”
UNDERSTANDING THE ORDERS: “PROTECTING THE NATION FROM FOREIGN
TERRORIST ENTRY INTO THE UNITED STATES”

• On January 27, 2017, President Donald J. Trump signed the executive order titled
“Protecting the Nation from Foreign Terrorist Entry into the United States.” The order
barred entry to the United States to all individuals with immigrant and non-immigrant visas
from Iraq, Iran, Libya, Somalia, Sudan, Syria, and Yemen for a period of 90 days.
Refugees worldwide were subject to an entry ban for 120 days, and refugees from Syria
were indefinitely banned. In subsequent days, federal lawsuits were filed in New York,
Massachusetts, Virginia, and Washington on behalf of travelers denied entry into the U.S.
from one of the seven affected countries.

• On February 3, a Federal District Court halted the implementation of the executive order
with a temporary restraining order; also that day, the state of Hawaii filed a lawsuit asking
the court to block the order’s implementation.

• On February 4, the Department of Justice appealed the February 3 restraining order to the
Ninth Circuit Court of Appeals.

• On February 9, the Ninth Circuit Court of Appeals unanimously ruled to deny the Justice
Department’s request for a stay.

• On March 6, rather than continue to litigate the first executive order, President Trump
withdrew the first executive order and signed a revised order, which was intended to go
into effect on March 16. The revised order removed Iraq from the list of countries facing
the 90-day travel ban. Additionally, the order removed the indefinite ban on Syrian
refugees and clarified that individuals with a valid visa to enter the U.S. would be
permitted to do so, regardless of their country of origin.

• On March 8, Hawaii filed another legal challenge to this revised ban.

• On March 15, a U.S. District Judge issued a temporary restraining order, blocking the
executive order from taking effect on March 16. On March 16, a second judge issued a
preliminary injunction related to the order.

• On March 29, a federal judge in Hawaii extended an order that blocked the ban from
nationwide implementation until Hawaii’s lawsuit was decided.

• On June 12, the Ninth Circuit Court largely upheld the injunction on the revised travel ban.

• On June 26, the U.S. Supreme Court allowed parts of the revised order to go into effect;
oral arguments are scheduled to be heard in October 2017 (after drafting of this report).
The Supreme Court’s decision upholds the revised order with the exception of those with
“any bona fide relationship with a person or entity in the United States,” which is being
defined as those with certain family connections in the U.S. (guidance from the State
Department indicated that only parents, step-parents, spouses, children, step-children, adult
sons/daughters, sons-/daughters-in-law, and siblings apply, but later added fiancées and
grandparents as well); students accepted by a U.S. university; individuals with job offers
at U.S. companies; and lecturers invited to address an American audience.

• The partial ban went into effect the evening of Thursday, June 29, and expired on
September 24. A new ban was then instituted, scheduled to take effect on October 18,
which struck the country of Sudan from the list but added Chad, North Korea, and
Venezuela (limited to government officials and their families).

• On October 10, the U.S. Supreme Court dismissed one of two pending lawsuits related to
the travel ban based on the argument that the ban in question had expired.

• On October 17, a federal judge in Hawaii blocked the revised travel ban, scheduled to go
into effect on October 18. As of the writing of this report, restrictions on North Korea and
Venezuela will be permitted to go into effect.
REACTION TO THE ORDER

The U.S. medical and scientific community responded immediately and forcefully to both executive orders. Leading national medical groups, including the AMA, Accreditation Council for Graduate Medical Education (ACGME), American Association of Colleges of Osteopathic Medicine (AACOM), Association of American Medical Colleges (AAMC), American Hospital Association (AHA), American Medical Student Association (AMSA), American Osteopathic Organization (AOA), Committee of Interns and Residents (CIR), and National Medical Association (NMA) all registered their serious concerns, often multiple times, over the following months. The Educational Commission for Foreign Medical Graduates (ECFMG), the body that evaluates and certifies qualified graduates of foreign medical schools prior to their entry into the U.S. graduate medical education system, dedicated an entire page of resources on its website related to the executive order.

Individual specialty societies also spoke out. The American College of Cardiology (ACC), American College of Physicians (ACP), American Society for Clinical Oncology (ASCO), American Academy of Family Physicians (AAFP), and American Academy of Pediatrics (AAP), among others, all expressed unease with the content and implications of the executive orders.

On June 12, the AAMC filed an amicus brief with the Supreme Court in opposition to the government’s petition for a stay against lower court injunctions against the executive order. Twenty-one organizations joined the brief: the AAFP; AAP; American Association of Colleges of Nursing (AACN); American Association of Colleges of Pharmacy (AACP); American College of Healthcare Executives (ACHE); American College of Obstetricians and Gynecologists (ACOG); ACP; American Dental Education Association (ADEA); American Nurses Association (ANA); American Psychiatric Association (APA); American Public Health Association (APHA); Association of Academic Health Centers (AAHC); Association of Schools and Programs of Public Health (ASPPH); Association of Schools of Allied Health Professions (ASAHP); Association of University Programs in Health Administration (AUPHA); Greater New York Hospital Association; Hispanic-Serving Health Professions Schools, Inc. (HSHPS); NMA; National Resident Matching Program (NRMP); Physician Assistant Education Association (PAEA); and Society of General Internal Medicine (SGIM).

As the brief noted, “Individuals from outside the United States play a critical role in the delivery of healthcare in America...Non-U.S. health professionals hail from around the world, including from the six countries subject to the Executive order’s suspension of entry. Economists estimate that more than seven thousand physicians currently working in the United States received training in the six countries, and that those doctors collectively provide fourteen million patient visits each year...Physicians from outside the United States ‘situate [themselves] on the front lines of medical need,’ including rural and other underserved communities, Native American communities, and U.S. Department of Veterans Affairs hospitals. In Alabama, for example, ‘Syria ranks fourth as a source of doctors for medically-needy areas ... behind India, Pakistan and the Philippines’.”

The brief goes on to describe additional implications: “Collaborative international efforts, especially strengthening the capacity of national health systems, are essential to prevent and prepare for an array of threats, from infectious disease pandemics to the silent killers of chronic non-communicable diseases. Any constraint on the participation of recognized experts in the free exchange of scientific research and collaboration impairs the collective knowledge of our healthcare community and jeopardizes American lives.”
Innovation and medical research were also highlighted in the brief: “The Executive order also has the potential to adversely affect patient care by constraining medical research and innovation. In 2016, all six American winners of the Nobel Prize in economics and scientific fields were immigrants. Moreover, since 2000, immigrants have been awarded 40%—or 31 of 78—of the Nobel Prizes won by Americans in chemistry, medicine, and physics. An analysis of the U.S. Patent and Trademark Office’s online database shows that 76% of patents awarded to the top ten patent-producing U.S. universities in 2011 listed at least one inventor who had been born in another country. During that same period, 56% of all patents were awarded to inventors who were students, postdoctoral fellows, or staff researchers from another country. Because non-U.S. post-doctorate students are increasingly relied upon to counter a decrease in U.S. students pursuing biomedical research in this nation, chilling their participation could adversely affect biomedical research and our health security.”

VISA IMPLICATIONS

As noted in Council on Medical Education Report 11-A-09, “Rationalize Visa and Licensure Process for IMG Residents,” the two most commonly used temporary, nonimmigrant classifications by IMGs are the J-1 Exchange Visitor program and the H-1B Temporary Worker classification.

Most IMGs in graduate medical education (GME) programs arrive under the J-1 Exchange Visitor Program, although the H-1B Temporary Worker category has been increasingly utilized. Data collected via the AMA’s National GME Census reflect changes in the ease or difficulty of obtaining different visas. Between 2001 and 2008, there was an increase in IMGs in residency programs under H status from 1,474 to 4,777. Meanwhile, IMGs under J status declined over the same period from 5,473 to 4,152. Since then, however, more IMGs have been training with J-1 visas. In 2012 there were 4,059 residents with H visas, and 5,200 with J visas; by 2015 there were 2,889 IMG residents with H visas and 6,394 with J visas. Additional analysis of the AMA’s National GME Census reveals that during the 2016/2017 academic year, 2,477 physicians who were born in the seven countries affected by the original executive order were participating in GME in the U.S. Of those, 615 (24.8 percent) were training here with a visa. The J-1 visa is a temporary, non-immigrant visa, meant to enhance educational and cultural exchange and promote mutual understanding between the U.S. and other countries. The ECFMG is the only authorized J-1 visa sponsor of foreign national physicians in U.S. clinical training programs. In 2016/2017, the ECFMG sponsored more than 10,000 individuals who are training in U.S. GME programs in 48 states plus the District of Columbia and Puerto Rico. The majority of these physician trainees were in primary care programs: 50 percent in internal medicine, 10 percent in pediatrics, and 7 percent in family medicine. The ECFMG also reports that in the 2017 NRMP Match, while the overall match rate of non-U.S. citizen IMGs increased slightly, fewer IMGs participated in the Match process. The ECFMG further reports that the number of J-1 visa applications it has received for the 2017/2018 year has declined 33 percent from Iran and 60 percent from Syria, while remaining flat in Libya and Yemen. As of August 15, 2017, 97.8% of the 2,766 physicians initially sponsored by ECFMG for J-1 visa status had successfully secured this status and arrived at their U.S. training programs. Of the 57 initially-sponsored J-1 physicians who are nationals of the countries identified in Executive Order 13780, 50 (87.7%) have successfully secured J-1 status and reported to their training program. Of the 7 (12.3%) who have not yet reported to their programs in J-1 status, 5
already are in the United States in another visa status and awaiting a change of status through U.S. Citizenship and Immigration Services.36

A program known as the Conrad 30 Waiver program, which is intended to lessen physician shortages in medically underserved areas, allows physicians with J-1 status to apply for a waiver for the two-year residence requirement upon completion of the J-1 program (individuals with J-1 status are otherwise required to return to their country of last permanent residence for two consecutive years prior to being permitted to apply for permanent resident status in the U.S.). Participants in the Conrad 30 Waiver program are required to practice medicine for a minimum of three years in an area designated by the U.S. Department of Health and Human Services (HHS) as a health professional shortage area (HPSA), medically underserved area (MUA), or medically underserved population (MUP). At the conclusion of that three-year period, waiver recipients can apply for an immigrant visa and permanent resident status.37

The Conrad State 30 and Physician Access Act (S. 898 and H.R. 2141) is intended to address the most recent extension of the Conrad State 30 Program, which was scheduled to expire on April 28. The AMA strongly supports adoption of the Act, writing that “J-1 visa waivers play a significant role in placing physicians in communities that face healthcare access challenges. Many communities, including rural and low-income urban areas, struggle to attract physicians to meet their patient needs. This legislation will help ensure continued access to care in medically underserved communities across the U.S.”38 As of the writing of this report, these bills had been referred to both the Senate and House Committees on the Judiciary.

J-1 Visas and the 2017 Match

The timing of the executive order was extremely disruptive to IMGs applying for residency training programs through the NRMP match, as well as for institutions and program directors seeking to fill their slots. The NRMP was concerned enough to issue a February 3 statement: “We ask the medical education community to support all international medical graduates and their families during these difficult times. Please be assured that NRMP will do all it can to address the uncertainties the order has created. As for the current Match cycle, we hope that applicants and programs will continue to rank each other in the order of true preference, based on the qualifications and qualities each seeks in the other.”39 Although no data exist to support this claim, the Council on Medical Education has heard anecdotally that some GME programs struggled to justify ranking qualified applicants from the list of countries affected by the executive order because of concerns about filling their programs and having enough resident staff on hand to fully serve their local patient populations.

H-1B Visas

In March, U.S. Citizenship and Immigration Services (USCIS) reported that it would temporarily suspend premium processing of H-1B visas beginning on April 3.40 H-1B visas grant temporary work status for immigrants who work for a specific employer. A recent JAMA article41 noted that physicians practicing in the U.S. with H-1B status accounted for 1.4% of all physicians actively delivering patient care nationwide in 2016 (more than 10,000 physicians). Physicians with this visa status, however, make up much larger percentages of the practicing physician workforce in certain states. For example, of practicing physicians in the following states, 4.7 percent in North Dakota are authorized to work through the H-1B visa program, 4 percent in Rhode Island, 3.9 percent in Michigan, and 3.6 percent in Delaware. It is worth noting, however, that USCIS typically suspends premium processing annually. The primary difference in this suspension, and likely the reason why...
it garnered more attention, is that this year’s suspension period was longer (potentially up to six months).

On June 23, USCIS announced that the department would resume the expedited processing of H-1B visas for physicians seeking such status under the Conrad 30 waiver program. As of the writing of this report, premium processing remains suspended for other categories of H-1B petitions.

**IMPLICATIONS FOR RESEARCHERS AND GLOBAL DATA SHARING**

Physician scientists and researchers were quick to note the obstacles the executive order would introduce into the heretofore collaborative nature of scientific research, which has led to life-saving medical advancements at home and abroad. There were concerns that existing research partnerships might be threatened or terminated and that the next generation of U.S. researchers and biomedical engineers might be depleted as talented individuals from other countries choose to settle and work outside of the U.S.

A group of almost 200 organizations, ranging from professional scientific, engineering, and education societies, as well as leading research universities, signed a letter to President Trump vocalizing their concerns regarding the January executive order. The letter notes, “Scientific progress depends on openness, transparency, and the free flow of ideas and people, and these principles have helped the United States attract and richly benefit from international scientific talent...The Executive order will discourage many of the best and brightest international students, scholars, engineers and scientists from studying and working, attending academic and scientific conferences, or seeking to build new businesses in the United States. Implementation of this policy will compromise the United States’ ability to attract international scientific talent and maintain scientific and economic leadership.”

Furthermore, since the first order was signed in January, more than 41,000 academics and researchers from a variety of fields, including 62 Nobel Laureates, have signed a statement attesting that “The EO [Executive order] significantly damages American leadership in higher education and research...The proposed EO limits collaborations with researchers from these nations by restricting entry of these researchers to the US and can potentially lead to departure of many talented individuals who are current and future researchers and entrepreneurs in the US. We strongly believe the immediate and long term consequences of this EO do not serve our national interests.”

As noted in a recent article in the *New England Journal of Medicine*, “Whether we are concerned about the competence of the physicians who will care for us when we are ill, the biomedical enterprise that represents one sixth of our economy, the jobs created by academic medical centers, or our global leadership position in health and health care, immigration policy that blocks the best from coming to train and work in the United States and blocks our trainees and faculty from safely traveling to other countries is a step backward, one that will harm our patients, colleagues, and America’s position as a world leader in health care and innovation.”

**INSTITUTIONAL IMPLICATIONS AND PATIENT ACCESS TO CARE**

According to research generated by The Immigrant Doctors Project, physicians from Iran, Libya, Somalia, Sudan, Syria and Yemen provide 14 million doctors’ appointments each year, and almost all Americans (94%) reside in a community that hosts at least one doctor from one of the countries specified in the executive order.
As previously noted, concerns have been voiced that regardless of country of origin, qualified non-US citizen IMGs will in the future pursue training and employment in other countries. Yet we know that higher proportions of IMGs, compared to U.S. medical school graduates, provide care to socioeconomically disadvantaged patients, and health care systems and patients rely heavily on foreign-born physicians. According to a recent article in the New York Times, “in Coudersport, Pa., a town in a mountainous region an hour’s drive from the nearest Walmart, Cole Memorial Hospital counts on two Jordanian physicians to keep its obstetrics unit open and is actively recruiting foreign specialists. In Fargo, N.D., a gastroenterologist from Lebanon — who is among hundreds of foreign physicians in the state — has risen to become vice president of the North Dakota Medical Association. In Great Falls, Mont., 60 percent of the doctors who specialize in hospital care at Benefis Health System, which serves about 230,000 people in 15 counties, are foreign doctors on work visas.” Findings from a recent survey from a physician recruiting agency further highlight this country’s need for foreign-born physicians, noting that just over eight percent of practicing physicians and less than three percent of trainees believe that practicing in a rural area is desirable.

Some specialties rely more heavily on IMGs. According to data from the 2017 NRMP Match, primary care continues to depend on foreign-born physicians. Of 7,233 positions offered in internal medicine, 2,003 were filled by non-U.S. IMGs. Of 3,356 positions offered in family medicine, 337 were filled by non-U.S. IMGs, and of 2,738 positions offered in pediatrics, 253 were filled by non-U.S. IMGs. Certain subspecialties also depend heavily on non-U.S. citizen graduates of international medical schools. The NRMP notes that in 2017, these individuals filled 45.1% of nephrology fellowship positions, 41.6% of vascular neurology positions, 39.3% of endocrinology/diabetes/metabolism positions, 37% of interventional pulmonology positions, and 35.3% of abdominal transplant surgery positions.

RELEVANT AMA POLICY

Policy D-255.991, “Visa Complications for IMGs in GME,” directs our AMA to work with the ECFMG to minimize delays in the visa process for international medical graduates applying for visas to enter the U.S. for GME and/or medical practice; promote regular communication between the Department of Homeland Security and AMA IMG representatives to address and discuss existing and evolving issues related to the immigration and registration process required for international medical graduates; and work through the appropriate channels to assist residency program directors, as a group or individually, to establish effective contacts with the State Department and the Department of Homeland Security, in order to prioritize and expedite the necessary procedures for qualified residency applicants and reduce the uncertainty associated with considering a non-citizen or permanent resident IMG for a residency position. It also calls on our AMA to study, in collaboration with the ECFMG and the ACGME, the frequency of such J-1 Visa reentry denials and their impact on patient care and residency training, and, with other stakeholders, to advocate for unfettered travel for IMGs for the duration of their legal stay in the US in order to complete their residency or fellowship training to prevent disruption of patient care.

Policy D-255.985, “Conrad 30 - J-1 Visa Waivers,” directs our AMA to advocate for solutions to expand the J-1 Visa Waiver Program to increase the overall number of waiver positions in the U.S. in order to increase the number of IMGs who are willing to work in underserved areas to alleviate the physician workforce shortage; work with the Educational Commission for Foreign Medical Graduates and other stakeholders to facilitate better communication and information sharing among Conrad administrators, IMGs, US Citizenship and Immigration Services and the State Department; and continue to communicate with the Conrad 30 administrators and IMG members to share information and best practices in order to fully utilize and expand the Conrad 30 program.
CONCLUSIONS AND AREAS FOR FURTHER STUDY

Ultimately, the real impact of the executive order will not be known until it becomes clear how the language of the revised ban is interpreted and applied at U.S. points of entry both at home and in consular offices abroad. The Supreme Court’s ruling would seem to imply that practicing physicians and resident physicians with a job offer from a U.S. institution will indeed be permitted to travel to and from the United States. However, anecdotal evidence indicates that several incoming resident trainees have either not been able to obtain a visa or have experienced significant delays, preventing them from starting residency on July 1; also, an Iranian researcher with a valid J-1 visa and job offer as a visiting scholar was prevented from entering the country on July 11.67,68

As noted previously, even the specter of immigration limitations can have an effect on individuals seeking to enter the United States. As a recent article observes, “Even with the travel restrictions on hold, admissions from the six nations fell dramatically in March and April, government data show. Compared with a year earlier, the number of people admitted from Iran, Libya, Somalia, Sudan, Syria and Yemen was down by about half year over year. It was unclear whether that was primarily due to fewer people seeking to travel to the U.S. or to the administration rejecting more applications.”69

Although not the focus of this report, what is less clear at this time is how the ruling will apply to foreign students seeking to apply to U.S. medical schools. As a parallel, we might look to the immigration environment immediately following the 2001 terrorist attacks. As one recent article notes, “Student visa applications dropped by 25 percent between 2001 and 2002, and the number of rejections rose from 25 to 34 percent between 2001 and 2003; and perhaps as a result of those post-9/11 policies, the number of international students enrolled at universities dropped for several years, says the 2009 report by the Council on Foreign Relations. ‘Overall, the number of foreign students attending American universities would have been about 25 percent higher if the pre-9/11 growth rates had continued,’ the report says. During that same time period, the report continues, international enrollment in the United Kingdom, France, Australia, Japan, and Germany surged as students went elsewhere.”70 The effects of the executive order on medical school enrollment bear monitoring, as a diverse body of medical students is critical to the creation and retention of a diverse physician workforce.

If there is a bright side to the executive orders, it is this: extensive and very public discussions are taking place in multiple venues, all of which provide an excellent opportunity to educate the American people regarding the crucial, life-saving role played in this country by foreign-born physicians. Additional dialogue regarding the importance of collaborative, international research is also valuable and necessary. The Council on Medical Education therefore will continue to follow this issue and report back to the House of Delegates as necessary.
REFERENCES


29 Ibid.
30 Ibid.
33 Personal Communication from Sarah Brotherton, Director, Data Acquisition Services, American Medical Association.
34 Personal Communication from William Pinsky, President and CEO, Educational Commission for Foreign Medical Graduates.
35 Ibid.
36 Ibid.


58 Ibid.


At the 2016 Interim Meeting, the House of Delegates referred Resolution 206, “Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers),” which was sponsored by the Medical Student Section. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2017 Interim Meeting. Resolution 206-I-16 asked:

That our American Medical Association (AMA) advocate that the “deficit-neutrality” component of the current US Department of Health and Human Services (HHS) rule for Section 1332 waiver qualifications be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval; and

That our AMA study reforms that can be introduced under Section 1332 of the Affordable Care Act (ACA) in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same.

This report provides background on Section 1332 waivers, outlines regulatory activity on Section 1332 waivers, highlights Section 1332 waiver applications and approvals, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Section 1332 of the ACA established a new waiver supporting state innovation in order to enable states to experiment with and implement different models to provide health insurance coverage to their residents. Under Section 1332, some of the ACA’s private insurance and coverage provisions can be waived, including those pertaining to premium tax credits and cost-sharing reductions for plans offered through the marketplaces, the individual and employer responsibility requirements and standards for health insurance marketplaces and qualified health plan standards. Other sections of the ACA cannot be waived under Section 1332, including those addressing guaranteed issue and community rating, the law’s prohibition against insurers denying coverage or charging higher premiums to people with pre-existing conditions, the ban on annual and lifetime limits, and the ability of adult dependents up to age 26 to be covered on their parents’ health plans.
Under Section 1332, the Secretaries of HHS and the Treasury are granted the authority to approve a request for a Section 1332 waiver only if the proposal meets the following four criteria:

1. The proposal will provide coverage to at least a comparable number of the state’s residents as would be provided absent the waiver;
2. The proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state’s residents as would be provided absent the waiver;
3. The proposal will provide coverage that is at least as comprehensive for the state’s residents as would be provided absent the waiver; and
4. The proposal will not increase the federal deficit.

If a Section 1332 waiver is approved, a state may receive funding equal to the amount of forgone federal financial assistance that would have been provided to its residents enrolled in marketplace coverage pursuant to the ACA, a process referred to as pass-through funding. Pass-through funding is capped at the amount of forgone marketplace subsidies and does not account for any other changes in federal spending or revenues as a result of the waiver. Accordingly, pass-through funding is especially essential for Section 1332 waivers under which individuals and/or small employers in the state would no longer qualify for premium tax credits, cost-sharing reductions and/or small business credits for which they would otherwise be eligible. For such waivers, the aggregate amount of such credits or reductions that would have been paid on behalf of consumers in the marketplaces had the state not received such waiver would instead be paid to the state to implement its Section 1332 waiver. Section 1332 waivers, which have been available since the beginning of this year, may be approved for periods up to five years and can be renewed.

REGULATORY ACTIVITY ON SECTION 1332 WAIVERS

A final regulation addressing the application, review, and reporting process for Section 1332 waivers was issued in February 2012. Under the final regulation, a state submitting an application for a Section 1332 waiver must provide actuarial analyses and certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other necessary information to show the proposed waiver’s compliance with the ACA criteria for Section 1332 waivers as noted above. Specific to deficit reduction, the economic analyses submitted by the state are required to include a detailed 10-year budget plan that is deficit neutral to the federal government. The final regulation also allows states to submit a single application for a Section 1332 waiver along with existing waivers applicable to Medicare, Medicaid and the Children’s Health Insurance Program (CHIP), which could include Section 1115 (of the Social Security Act) waivers, which currently allow states to implement experimental, pilot, or demonstration projects in the Medicaid and CHIP programs.

In December 2015, the Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury released guidance that addressed how the agencies will evaluate state applications for Section 1332 waivers. Addressing the ACA’s deficit neutrality requirement, the guidance stated that waivers must not increase the federal deficit over the period of the waiver or in total over the ten-year budget plan submitted by the state. Pertinent to referred Resolution 206-I-16, the agencies stated in the guidance that “a waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement.” In addition, the guidance stated that although a state may submit a coordinated waiver application, in such a case each waiver will be evaluated independently according to applicable federal laws. Importantly, the guidance stated that there would be limitations to Section 1332 waiver applications for states that use healthcare.gov for their marketplaces, as the federal platform cannot accommodate different rules for different states.
Therefore, the agencies note that states contemplating waivers that include changes to the 
calculation of marketplace financial assistance as well as plan management, for example, may 
consider establishing and administering their own platform.4

In March 2017, HHS Secretary Price sent a letter to governors encouraging states to submit Section 
1332 waiver proposals, including proposals for high-risk pool/state-operated reinsurance programs. 
In the letter, Secretary Price referenced Alaska’s waiver application, which was approved in July 
2017, and sought federal support for a state-managed reinsurance program. The Secretary noted 
that if a state’s plan under its waiver proposal is approved, a state may be able to receive pass-
through funding to help offset a portion of the costs for the high-risk pool/state-operated 
reinsurance programs.

In May 2017, CMS released a checklist for Section 1332 waiver applications, which also included 
specific items pertaining to applications that include high-risk pool/state-operated reinsurance 
programs. Pertaining to deficit neutrality, the checklist states as part of waiver applications, states 
must include an economic analysis to support the state’s finding that the waiver will not increase 
the federal deficit over the five-year waiver period or in total over the ten-year budget period. 
Additionally, the checklist stipulates that the deficit analysis submitted by the state should show 
yearly changes in the federal deficit due to the waiver.6

SECTION 1332 WAIVER APPLICATIONS AND APPROVALS

As Section 1332 waivers have only been available starting this year, activity on waivers has been 
relatively limited. At the time that this report was prepared, nine states had submitted waiver 
applications – Alaska, California, Hawaii, Iowa, Massachusetts, Minnesota, Oklahoma, Oregon and 
Vermont. The waiver applications of three states - Hawaii, Alaska and Minnesota - have been 
approved. Of note, Minnesota’s waiver was approved with less federal pass-through funding than 
was requested by the state. The waiver applications of California and Oklahoma were withdrawn, 
while Vermont’s was put on hold.7 Hawaii’s Section 1332 waiver allowed the state to keep its 
longstanding employer coverage provisions resulting from the state’s Prepaid Health Care Act, 
which requires employers to provide more generous coverage than is required under the ACA. As 
such, Hawaii’s waiver sought to waive the ACA requirement that a Small Business Health Options 
Program (SHOP) marketplace operate in Hawaii and other provisions related to SHOP 
marketplaces, including the requirement that the small business tax credits could only be available 
through the SHOP.8,9

Alaska’s waiver allows the state to implement the Alaska Reinsurance Program (ARP) for 2018 
and subsequent years. The ARP will cover claims in the individual market for individuals with one 
or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers will 
relinquish both premiums received for such individuals as well as claims they would have paid 
absent the waiver. As a result of the ARP, it is expected that premiums will be 20 percent lower in 
2018 than absent the waiver, and 1,460 additional individuals will have health insurance coverage. 
Because the ARP will lower premiums, the second lowest cost silver plan premium is reduced, 
which results in the federal government spending less on premium tax credits.10 The waiver 
application of Minnesota would create the Minnesota Premium Security Plan, which was estimated 
to yield a 20 percent reduction in average premiums in 2018.11 While Minnesota’s waiver was 
approved, the full amount the state requested in its waiver for federal pass-through funding to 
financially support its reinsurance program was not approved. Only federal pass-through funding 
reflecting savings from less spending on premium tax credits and cost-sharing reductions was 
approved, not the amount also requested by the state that reflects federal savings due to lower 
premiums for plans under the state’s Basic Health Program.12 The waiver application of Oregon,
which was still under review when this report was prepared, anticipates that its waiver to establish
the Oregon Reinsurance Program will reduce premiums, including those for the second-lowest cost
silver plan, by 7.5 percent in 2018 (net of the premium assessment), with an increase in enrollment
in the individual market by approximately 1.7 percent in the same year.13

Likewise, Iowa’s waiver application includes a reinsurance program. However, due to concerns at
the time of its waiver application that there would be no insurers participating in the state’s
marketplace in 2018, Iowa also proposed to make substantive changes to ACA requirements, and
cited the need for “emergency regulatory relief.” Iowa’s Section 1332 waiver proposal calls for the
creation of a single Proposed Stopgap Measure plan that would be the only plan offered by insurers
in the marketplace, and provide coverage similar to that offered by a standard silver plan. In
addition, the initial waiver application proposes replacing the ACA’s premium tax credits with flat
premium subsidies based on age and income, as well as eliminating cost-sharing reductions
(CSRs).14 In response to concerns over the state’s waiver application eliminating cost-sharing
reductions, Iowa submitted a supplement to its waiver application in order to provide additional
cost-sharing support to individuals with incomes between 133 and 150 percent of the federal
poverty level (FPL), to be implemented similarly to how cost-sharing reductions are currently
provided to this population.15 Of note, cost-sharing reductions are currently provided to individuals
with incomes up to 250 percent of the FPL under the ACA. In addition, the state has requested that
HHS waive the requirements that Section 1332 waivers include actuarial analyses, actuarial
certifications, and economic analyses, including those which support the state’s finding that the
waiver will not increase the federal deficit over the period of the waiver or in total over the 10-year
budget period.16 At the time that this report was prepared, Iowa no longer has any counties at risk
of having no insurer participating in the state’s marketplace in 2018.17

In response to the market volatility the uncertainty about continued funding for CSRs has caused,
Massachusetts submitted a waiver request that requested waiver of CSRs and instead create a
Premium Stabilization Fund that would make payments to health plans equivalent to those that
would be made under federal CSR payments. Massachusetts requested expedited review of its
waiver, which if approved would be effective January 1, 2018 for an initial period of at least one
year, and likely blunt premium increases that would otherwise occur in the marketplace due to the
uncertainty as to whether federal CSR funding will continue.18

RELEVANT AMA POLICY

Policy D-165.942 advocates that state governments be given the freedom to develop and test
different models for covering the uninsured, provided that their proposed alternatives meet or
exceed the projected percentage of individuals covered under an individual responsibility
requirement while maintaining or improving upon established levels of quality of care, ensure and
maximize patient choice of physician and private health plan, and include reforms that eliminate
denials for pre-existing conditions. Policy H-165.845 supports outlined principles to guide in the
evaluation of state health system reform proposals, including:

- Health insurance coverage for state residents should be universal, continuous, and portable.
  Coverage should be mandatory only if health insurance subsidies are available for those
  living below a defined poverty level.
- The health care system should emphasize patient choice of plans and health benefits,
  including mental health, which should be value-based. Existing federal guidelines
  regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and
  Federal Employees Health Benefits Program [FEHBP] regulations) should be used as
  references when considering if a given plan would provide meaningful coverage.
The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.

The administration and governance system should be simple, transparent, accountable, efficient, and effective in order to reduce administrative costs and maximize funding for patient care.

Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.

Policies D-165.966 and H-165.855 advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. Policy D-165.966 also supports changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds.

DISCUSSION

The AMA has long advocated that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. The Council believes that Section 1332 of the ACA provides states with a unique opportunity to build upon the progress that has been made in expanding health insurance coverage and choice under the ACA. With Section 1332 waivers, states could devise new and innovative approaches to provide quality health insurance coverage to more people, as well as make health insurance coverage more affordable.

The Council believes that it is imperative that approved State Innovation Waivers follow the criteria outlined in Section 1332 of the ACA and related regulations: that Section 1332 waiver proposals will provide coverage to at least a comparable number of the state’s residents as would be provided absent the waiver; provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state’s residents as would be provided absent the waiver; provide coverage that is at least as comprehensive for the state’s residents as would be provided absent the waiver; and not increase the federal deficit.

However, additional actions should be taken, either administratively or legislatively, to make Section 1332 waivers more workable for states, and be potentially more advantageous for state residents. Under current law, Section 1332 waivers are required to not add to the federal deficit, and current guidance states that waivers must not increase the federal deficit over the period of the waiver or in total over the ten-year budget plan submitted by the state. However, the language in the federal guidance from 2015 also stated that “a waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement.” The Council believes that there could be unintended consequences for states seeking to innovate to require deficit neutrality in each individual year of a Section 1332 waiver. The Council recognizes that it would be reasonable for some waivers to project deficits in years one or two of a waiver as a result of start-up and other costs, and savings in subsequent years that offset the earlier deficits. The Council believes it is essential for Section 1332 waivers to remain deficit neutral over the period of the waiver (which may not exceed five years unless renewed), as well as in total over the ten-year budget plan submitted by the state.

The Council also believes that federal pass-through funding provided to states to implement their Section 1332 waivers should capture all federal budgetary savings achieved by the waiver. Under current law, the amount of federal pass-through funding is equal to an annual estimate of forgone...
marketplace subsidies and financial assistance that would have otherwise been provided pursuant to the ACA. If a Section 1332 waiver creates additional federal savings outside of the scope of marketplace subsidies, such as reducing the cost of the tax exclusion for employer-sponsored coverage, such savings should also be included in the amount of federal pass-through funding provided to the state to finance its Section 1332 waiver.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 206-I-16, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the criteria outlined in Section 1332 of the Affordable Care Act for the approval of State Innovation Waivers:
   a. The waiver proposal will provide coverage to at least a comparable number of the state’s residents as would be provided absent the waiver;
   b. The waiver proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver;
   c. The waiver proposal will provide coverage that is at least as comprehensive for the state’s residents as would be provided absent the waiver; and
   d. The waiver proposal will not increase the federal deficit. (New HOD Policy)

2. That our AMA support the deficit neutrality requirement of Section 1332 waivers being enforced over the period of the waiver and in total over the ten-year budget plan submitted by a state, not in each individual year of the waiver. (New HOD Policy)

3. That our AMA support legislation to allow other federal savings projected to be achieved as a result of a Section 1332 waiver, including any reductions in the cost of the tax exclusion for employer-sponsored coverage, to be included in the amount of federal pass-through funding provided to a state to subsidize state innovations. (New HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


2 Id.


4 Centers for Medicare & Medicaid Services and Department of the Treasury, supra note 1.


11 Tolbert and Pollitz, supra note 8.


16 Iowa Insurance Division, supra note 13.


At the American Medical Association’s (AMA) 2016 Interim Meeting, the House of Delegates adopted Policy D-450.954, “A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities,” which asked the AMA to study the impact of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) on Medicare payments to hospitals serving vulnerable populations and on potential health care disparities.

The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2017 Interim Meeting. This report provides background on the purpose and use of HCAHPS surveys and the role of safety net hospitals, explains the intersection of HCAHPS scores and safety net hospitals, explores how cultural competency influences patient satisfaction and HCAHPS scores, and outlines relevant legislation. The Council recommends policy to help shield safety net hospitals from the potentially negative financial impact that hospital quality program assessments may have on hospitals that serve a disproportionate share of patients with social risk factors and policy to recognize the importance of cultural competency in patient experience and treatment plan adherence.

BACKGROUND

The HCAHPS survey is the first national, standardized, publicly reported survey of patients’ perspectives of hospital care. HCAHPS has three goals. First, the survey is designed to produce data about patients’ perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to patients. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting of survey results serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

HCAHPS survey scores over a three-year period influence a portion of each hospital’s value-based purchasing (VBP) incentive payment. The VBP adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care delivered. The VBP adjusts Medicare’s payment rate to hospitals based on a set of defined process, outcome, and experience of care measures. The measures are represented in four different areas: Clinical Care (Process and Outcomes), Patient Experience of Care (HCAHPS), Efficiency, and Safety. As noted, the patient experience of care measure is based off of HCAHPS.
Safety net hospitals play a critical role in providing health care to vulnerable populations, and it is important to ensure that efforts to improve quality of care do not exacerbate existing health care disparities. Generally, safety net hospitals are financially stressed because they are chronically underfunded and payments are low. Because of these financial constraints, safety net hospitals may have fewer nurses and are more likely to be older buildings, which are factors largely beyond the hospital’s immediate control.  

Safety net hospitals serve many patients without the ability to pay and generally have sicker patients and a more complex patient case mix than traditional hospitals. Therefore, many safety net patients have conditions that require additional resources such as social work and behavioral health care; however, the hospitals often do not have the resources to devote to these services or the financial means to provide amenities that positively affect patient satisfaction.

**HCAHPS SCORES AND SAFETY NET HOSPITALS**

According to one recent study published in the *Archives of Internal Medicine*, hospitals that serve a disproportionate share of low-income and Medicaid patients generally scored lower than other hospitals on the HCAHPS patient experience care survey and were 60 percent less likely to meet HCAHPS performance benchmarks under the Medicare VBP program. Researchers compared HCAHPS performance and improvement for safety net hospitals with other hospitals from 2007 to 2010. While scores for both groups of hospitals improved over the four year period, the performance gap between them increased. Overall, 769 hospitals that treat the largest share of low-income patients scored 5.6 percentage points lower than their 2,327 non-safety net counterparts. It is worth noting that the HCAHPS survey is only available in six languages and therefore prohibits some patients from participating.  

The authors of the study surmised two explanations for the disparity between the two hospital groups. One explanation was that patients in safety net hospitals have different expectations than patients in other hospitals. The other explanation was that safety net hospitals have not done as good of a job focusing on the patient issues reflected in the survey.  

Safety net hospitals have pointed out that they are at a disadvantage and that their scores should be adjusted to take into consideration the diverse case mix, poverty, language barriers, and cultural issues specific to safety net hospitals. They state that the Centers for Medicare & Medicaid Services (CMS) should design incentive programs that reward safety net hospitals prior to implementing financial penalties.

**HCAHPS SCORES AND CULTURAL COMPETENCY**

Communication measures account for 50 percent of the HCAHPS patient experience index. As previously stated, patient characteristics such as race, ethnicity, and language preference may impact the perception of care provided. Language and communication barriers may lead to patient dissatisfaction and poor comprehension and treatment adherence. Patients and families who are non-white, speak a language other than English, and are on Medicaid report lower experience scores than those commercially insured, white, and English-speaking patients and families. Therefore, demographic and cultural differences seem to be important considerations in improving communication.

The National Quality Forum (NQF) has defined cultural competency as the “ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable.”
Cultural competency has been promoted as a strategy to enhance patient satisfaction and improve organizational performance.\(^{11}\)

Patient centered care has been an ongoing focus of the health care community to facilitate quality improvement.\(^{12}\) It follows that taking into account demographics and culture is necessary for aligning hospital services and patient preferences. For example, a study of California hospitals found that hospitals with greater cultural competency have better scores for doctor and nurse communication, staff responsiveness, hospital rating, and hospital recommendation.\(^{13}\)

**RELEVANT LEGISLATION AND REGULATORY ACTIVITY**

Recent legislation has addressed how to account for social risk factors in Medicare payment. The 21\(^{st}\) Century Cures Act requires Medicare to account for a patient’s background when calculating reductions in payments to hospitals under the Hospital Readmissions Reduction Program.\(^{14}\) In addition, the Hospital Inpatient Prospective Payment Systems (IPPS) rule requested feedback on how to account for social risk factors in the Inpatient Quality Reporting program. Also, in response to the IMPACT Act, the Assistant Secretary for Planning and Evaluation (ASPE) sponsored a committee of the National Academies of Sciences, Engineering and Medicine to specify criteria that could be used in determining which socioeconomic status factors should be accounted for in Medicare quality and payment systems. The committee released its report in December 2016.\(^{15}\) Additionally, at the direction of the Department of Health and Human Services, the National Academy of Medicine (NAM) released a report on how social risk factors may influence health care use, outcomes, and costs in Medicare payment and quality programs.\(^{16}\) Importantly, both the ASPE and NAM activities found that existing data sources used to capture social risk factors are insufficient for the purposes of developing better risk adjustment methodologies.

**RELEVANT AMA ACTIVITY AND POLICY**

Policy H-450.946 states that the AMA will advocate for effective quality management programs that incorporate substantial input by actively practicing physicians and physician organizations. Policy H-450.966 states that the AMA will seek an active role in any efforts to develop national medical quality and performance standards and measures; emphasize the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; and advocate that principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts, including that standards and measures shall have demonstrated validity and reliability, shall reflect current professional knowledge and available medical technologies, shall be linked to health outcomes and/or access to care, shall be representative of the range of health care services commonly provided by those being measured, shall account for the range of settings and practitioners involved in health care delivery, shall recognize the informational needs of patients and physicians, shall recognize variations in the local and regional health care needs of different patient populations, shall recognize the importance and implications of patient choice and preference, and shall recognize and adjust for factors that are not within the direct control of those being measured.

The AMA has numerous policies on the appropriate use of patient satisfaction surveys. Policy D-450.960 directs the AMA to urge CMS to modify the HCAHPS scoring system so that it assigns a unique value for each rating option available to patients. Policy H-450.982 states that efforts should be continued to improve the measurement of patient satisfaction and to document its
relationship to favorable outcomes and other accepted criteria of high quality care. Additionally, Policy D-385.958 directs the AMA to work with CMS and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment and to ensure that physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. Similarly, Policy H-406.991 states that patient satisfaction surveys should be used to help improve patient care and not be used for the purpose of determining physician payment.

Consistent with the AMA’s continued efforts to refine risk adjustment, Policy H-155.957 encourages further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services.

Policy H-295.897 promotes cultural competency training with the goal of emphasizing cultural competence as part of professional practice and encourages training opportunities for students and residents to learn cultural competency from community health workers.

In accordance with these policies, the AMA has advocated extensively for improvements to HCAHPS. The AMA always includes a section on improvements to HCAHPS in comments related to the Medicare physician fee schedule. The AMA successfully lobbied CMS to propose removing the pain questions from HCAHPS and clarifying that HCAHPS is a hospital level survey and that it is not appropriate to tie physician compensation or measure physicians based on HCAHPS scores.

Specifically, in the AMA’s recent comments on the IPPS Proposed Rule, the AMA advocated for continued refinements to HCAHPS and refinements to the risk adjustment methodology used in program measurements. Further, the AMA advocated for CMS’ consideration of measuring and accounting for social risk factors in Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs noting that the AMA continues to believe that in order to ensure the quality of care furnished by physicians and hospitals is assessed as fairly as possible, social risk factors must be taken into account.

DISCUSSION

Safety net hospitals play a critical role in providing needed health care to vulnerable populations. These hospitals provide a necessary function and often have more challenging patient populations and fewer resources to devote to patient care when compared to non-safety net hospitals. While patient satisfaction scores may provide an incentive for hospitals to devote more resources to the measure, safety net hospitals generally do not have the funding to do so. Although the Council believes that the goal of such patient satisfaction surveys should be to identify areas to improve patient outcomes and quality of care, the AMA must guard against efforts aimed at improving the quality of care that have the unintentional effect of stripping safety net hospitals of needed funding and thereby exacerbating health care disparities. Tying financial incentives to HCAHPS patient satisfaction scores may have the effect of financially penalizing such hospitals and unintentionally exacerbating existing inequalities in care.

Further, numerous studies have found that patient satisfaction is not necessarily an objective measure of quality. In a nationally representative sample, higher patient satisfaction was associated with lower emergency department use but with greater use of inpatient care, higher overall health care and prescription drug expenditures, and increased mortality. Therefore, the limitations of
patient experience surveys should be recognized. Additionally, the Council notes that, at times, a statistically minimal number of surveys may have a material effect on overall scores. To that end, the Council recommends reaffirming numerous policies emphasizing that such quality assessments should adjust for factors outside of the physician’s control and recognizing variation in different patient populations, policy stating that patient satisfaction surveys should not be a determinative measure of physician quality for payment purposes, and policy advocating for the continuation of efforts to improve patient satisfaction measurement.

Socioeconomic factors such as age, income, educational level, ethnicity and others have been identified as having a role in not only health care preferences but also health care outcomes. Such factors may present obstacles to successful outcomes and can widen health care disparities. Recognizing socioeconomic factors and focusing on cultural competency in care delivery may reduce racial and ethnic health care disparities and positively contribute to quality improvement. Therefore, the Council believes it is important not only to guard against patient satisfaction surveys unintentionally depriving safety net hospitals of needed funding but also to focus on ways to improve the patient experience. Accordingly, the Council recommends continuing to advocate for improved risk models that account for social risk factors in hospital quality program assessments. The Council notes that excluding a specific mention of HCAHPS from the recommendation and instead mentioning “hospital quality program assessments” makes the policy inclusive of the numerous hospital quality programs, including HCAHPS. Further, the Council recommends reaffirming policy promoting cultural competency training and recommends new policy recognizing the importance of cultural competency to patient experience and encouraging the implementation of such practices across health care settings.

While it may be difficult to determine whether patient satisfaction scores are a result of physician performance or demands and restrictions outside of the physician’s control, the Council believes valuable information can be gleaned from patient surveys. There is evidence supporting the premise that when patients better understand treatment plans, they are more likely to adhere to recommendations and return for follow up care in the future. The Joint Commission, which pools together best practices for HCAHPS scores, notes that positive patient perception of care may improve patient safety and staff retention. Additionally, patient experience of care quality and patient satisfaction are tied to the Triple Aim. Although experience may not necessarily be an indicator of quality, it is important for patient’s perceptions of care to be positive. These perceptions reflect the physician-patient relationship and support patient retention and shared decision-making.

The Council believes improving the patient experience is a shared goal in health care. It also believes that ensuring the financial viability of safety net hospitals is vital to providing care to the most vulnerable and fighting to reduce health care disparities. Therefore, the Council recommends continuing to work with CMS and others, including America’s Essential Hospitals, to address issues related to hospital quality program assessments.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-450.966 emphasizing that national medical quality and performance standards and measures should adjust for factors that are not within the direct control of those being measured and should recognize the variations in needs of different patient populations. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy D-385.958, which calls for the AMA to work with Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, should not be used as a determinative measure of physician quality for the purpose of physician payment and to ensure that physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-450.982 stating that efforts should be continued to improve the measurement of patient satisfaction and to document its relationship to favorable outcomes and other accepted criteria of high quality. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-295.897 promoting cultural competency training with the goal of emphasizing cultural competence as part of professional practice. (Reaffirm HOD Policy)

5. That our AMA support that the goal of hospital quality program assessments should be to identify areas to improve patient outcomes and quality of patient care. (New HOD Policy)

6. That our AMA recognize the importance of cultural competency to patient experience and treatment plan adherence and encourage the implementation of cultural competency practices across health care settings. (New HOD Policy)

7. That our AMA support that hospital quality program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities. (New HOD Policy)

8. That our AMA continue to advocate for better risk models that account for social risk factors in hospital quality program assessments. (New HOD Policy)

9. That our AMA continue to work with CMS and other stakeholders, including representatives of America’s Essential Hospitals, to address issues related to hospital quality program assessments. (New HOD Policy)

10. That our AMA rescind Policy D-450.954. (Rescind HOD Policy)

REFERENCES

1 Hospital Consumer Assessment of Healthcare Providers and Systems. Available at: http://www.hcahpsonline.org/home.aspx

Fiscal Note: Less than $500.

Paula Chatterjee, MPH, supra note 2.


Cultural Competence in Health Care: Is It Important for People with Chronic Conditions? Georgetown University Health Policy Institute. February 2004. Available at: https://hpi.georgetown.edu/agesociety/pubhtml/cultural/cultural.html


Weech-Maldonado, Robert MBA, PhD; Elliott, Marc PhD; Pradhan, Rohit PhD; Schiller, Cameron MS; Hall, Allyson PhD; Hays, Ron D. PhD. Can Hospital Cultural Competency Reduce Disparities in Patient Experiences With Care? Medical Care Office Journal of the Medical Care Section, American Public Health Association. November 2012. Available at: http://journals.lww.com/lww-medicalcare/Fulltext/2012/11001/Can_Hospital_Cultural_Competency_Reduce.10.aspx


Weech-Maldonado, supra note 11.


EXECUTIVE SUMMARY

As the House of Representatives and the Senate have been discussing and crafting legislation related to health reform, the Council spent the past year reviewing the substantial body of American Medical Association (AMA) policy pertaining to the AMA proposal for reform, as well as assessing whether to potentially revisit policy on certain health reform issues. The Council has concluded that the preponderance of AMA policy regarding coverage, choice and access remain relevant. However, in its review, the Council determined that it was necessary to revisit and modify policy on essential health benefits and the relative merits of high-risk pools versus reinsurance.

The Council believes there is an opportunity to include additional safeguards in AMA policy to ensure that patients have meaningful coverage that protects them against catastrophic expenses. While the AMA has long supported patient choice of health plan, AMA policy has also stressed that any health insurance purchased must provide meaningful coverage for hospital, surgical and medical care; protect patients against catastrophic expenses; and promote preventive services. AMA policy also underscores that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations, and that prohibitions on annual and lifetime limits should remain in place under any reform.

The Council notes that most of the health care claims costs associated with essential health benefits (EHB) are attributable to such services as hospital inpatient and outpatient care, physician services, and prescription drugs. These services are arguably viewed as fundamental components of health insurance coverage. Removing any benefits from the EHB requirements, or allowing waivers of such requirements, can cause insurers to cherry pick patients based on the services their plans cover, as well as hinder patient access to necessary services. If insurers are allowed to offer plans with skimpier coverage, plan designs could potentially discriminate against people with pre-existing conditions. In addition, individuals who use services and benefits no longer included in the EHBs could face substantial increases in out-of-pocket costs. As such, the Council is recommending that our AMA oppose the removal of categories from the EHB package. In addition, the Council believes that our AMA should also oppose waivers of EHB requirements that lead to EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses, being eliminated.

In addition, the Council re-evaluated AMA policy with respect to how to best subsidize the costs of high-cost and high-risk patients, who may have pre-existing conditions. Traditional high-risk pools have historically provided individuals with pre-existing conditions with second-class insurance, with waiting periods to get pre-existing conditions covered, higher premiums, potentially high deductibles, and lifetime limits on benefits. Considering the success of the Affordable Care Act’s reinsurance program, as well as state reinsurance programs, and in light of finite resources, the Council believes that resources should be directed to reinsurance programs. Reinsurance provides an equitable, fair and cost-effective mechanism to subsidize the costs of high-risk and high-cost patients, and protects patients with pre-existing conditions.
The American Medical Association (AMA) proposal to cover the uninsured and expand choice, used in AMA advocacy leading up to and following the enactment of the Affordable Care Act (ACA) and highlighted in AMA’s Voice for the Uninsured campaign, is based on numerous policies developed and/or refined by the Council on Medical Service, and adopted by the House of Delegates, during the 1990s and 2000s. The proposal removed the bias toward employment-based insurance and promoted a system of individually selected and owned health insurance coverage, using tax credits, individual responsibility, and other market regulations to maximize coverage gains, make coverage affordable, and ensure patient choice of health plan and physicians.

As the House of Representatives and the Senate have been discussing and crafting legislation related to health reform, the Council spent the past year reviewing the substantial body of AMA policy pertaining to the AMA proposal for reform, as well as assessing whether to potentially revisit policy on certain health reform issues. The Council has concluded that the preponderance of AMA policy regarding coverage, choice and access remain relevant. However, in its review, the Council determined that it was necessary to revisit and modify policy on essential health benefits and the relative merits of high-risk pools versus reinsurance.

This report provides background on the issues of essential health benefits, high-risk pools and reinsurance; assesses their impact on health insurance affordability; summarizes relevant AMA policy; and presents policy recommendations.

ESSENTIAL HEALTH BENEFITS

Background

Under the ACA, all qualified health benefits plans, with the exception of grandfathered individual and employer-sponsored plans, are required to offer at least the essential health benefits (EHB) package, including those offered in health insurance marketplaces and in the individual and small group markets outside of the marketplaces. The ACA specified that the EHB package must cover the following general categories of services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
• Prescription drugs;
• Rehabilitative and habilitative services and devices;
• Laboratory services;
• Preventive and wellness services and chronic disease management; and
• Pediatric services, including oral and vision care.

The Secretary of the US Department of Health and Human Services (HHS) has the responsibility to determine the scope of the EHB package, which the ACA specified should be equal to the scope of benefits under a typical employer-sponsored plan. Regulations addressing EHB stated that EHB shall be defined by state-specific benchmark plans. HHS also stated that “the EHB-benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state.” HHS outlined four benchmark plan options for states:

• The largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market;
• Any of the largest three state employee health benefit plans by enrollment;
• Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; and
• The largest insured commercial non-Medicaid health maintenance organization operating in the state.

Impact on Health Insurance Affordability

Concerns have been raised that certain categories of essential health benefits drive up premium costs. The Council notes that most of the health care claims costs associated with essential health benefits are attributable to such services as hospital inpatient and outpatient care, physician services, and prescription drugs. These services are arguably viewed as fundamental components of health insurance coverage. For example, Milliman estimated that removing maternity coverage from insurance coverage may lower premiums by $8 to $14 per month, depending on geographic, provider and other factors. In addition, a recent analysis conducted by RAND researchers projected that, for 2017, maternity care would account for four percent of per capita insurer spending, and mental health and substance abuse treatment would account for one percent of per capita insurer spending. Spending on prescription drugs was projected to be more substantial, accounting for approximately 22 percent of per capita insurer spending.

The ACA also prohibits annual and lifetime limits, but only for care that is considered to be under the umbrella of EHBs. In addition, the ACA requires health plans to cap out-of-pocket expenses of enrollees, but only for care that is considered EHBs. As such, several analyses have concluded that if EHB categories are removed or allowed to be waived, premiums would decrease, but individuals who use services and benefits no longer included in the EHBs could face substantial increases in out-of-pocket costs. If EHB categories are removed or allowed to be waived, health plans could react in multiple ways, including no longer covering affected categories; providing a level of coverage for affected categories (but caps on out-of-pocket spending, as well as annual and lifetime limits may not apply); or offer coverage “riders” for affected categories. Analyses have found that categories most likely to be removed from the EHB, if states are allowed flexibility to do so, include maternity care; mental health and substance abuse benefits; rehabilitative and habilitative services; certain pediatric services, including oral and vision care; and prescription drugs. The Council notes, for example, that riders for maternity services were available prior to enactment of the ACA. In addition, if prescription drugs were removed as an EHB category, plans may provide a level of coverage for them, but individuals who rely on expensive prescription drugs
could face an exponential increase in out-of-pocket spending due to the loss of the ACA’s financial protections afforded to EHB categories.

In addition, analyses have found that removing EHB categories or allowing EHB waivers could cause market segmentation.\cite{12,13,14} If categories are removed from EHB, individuals who do not foresee a need for removed services will be attracted to more affordable, less comprehensive plans. However, individuals in need of affected services, which could range from mental health to maternity services to pediatric services, would either not have any plan options or face much higher premiums for plans that offer at least some level of coverage for removed services. As such, health plans would be able to structure their offerings as to attract lower-risk and healthier enrollees, as sicker, higher-risk individuals would tend to gravitate toward richer, more generous coverage.

Finally, concerns have been raised that removing EHB categories or allowing waivers of EHBs could allow for mini-meds and other “sham” health insurance to have greater standing in the marketplace. As ACA’s protections against catastrophic costs are tied to EHBs, if EHBs are eliminated, individuals could increasingly enroll in health insurance coverage that does not protect them against catastrophic expenses. Notably, the health reform debates in the House of Representatives and the Senate have been impacted by the Congressional Budget Office’s definition of private health insurance coverage, which has been outlined as “consisting of a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals… The definition excludes policies with limited insurance benefits (known as mini-med plans); ‘dread disease’ policies that cover only specific diseases; supplemental plans that pay for medical expenses that another policy does not cover; fixed-dollar indemnity plans that pay a certain amount per day for illness or hospitalization; and single-service plans, such as dental-only or vision-only policies. In this estimate, people who have only such policies are described as uninsured because they do not have financial protection from major medical risks.”\cite{15}

AMA Policy Relevant to Essential Health Benefits

Policy H-165.846 states that existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. The policy also advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any EHB package for children. Policy H-165.865 states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the US Code. Policy H-165.848 states that under an individual mandate, individuals should be required to obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care. Policy D-180.986 states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against “sham” health insurers. Policy H-165.856 cautions that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. Policy H-185.964 opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations.
HIGH-RISK POOLS AND REINSURANCE

Background

The ACA established risk adjustment, reinsurance, and risk corridor programs to not only stabilize premiums during the early years of ACA implementation, but to blunt the impact of adverse risk selection. ACA’s risk adjustment program, which is permanent in nature, redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees, thereby removing insurer incentives to “cherry pick” healthier enrollees. The ACA’s temporary reinsurance program played a role in stabilizing premiums in the individual marketplace during the early years of ACA implementation. The program provided payments to plans that enrolled higher-cost individuals whose costs exceeded a certain threshold, also known as an attachment point, up to the reinsurance cap. The ACA’s temporary risk corridor program aimed to promote accurate premiums while there was uncertainty among insurers in the early years of the marketplaces about who would enroll and the cost of their care. The risk corridor program limited health plan losses and gains beyond an allowable range.16

The ACA established a temporary state-based high-risk pool program, known as the Pre-Existing Condition Insurance Plan (PCIP) program, in 2010, to be phased out when the key coverage provisions of the ACA became operational in 2014. HHS ran the PCIPs in 23 states and the District of Columbia, while 27 states administered their own programs. Individuals had to be uninsured for at least six months before enrolling, but otherwise, the program had no pre-existing condition exclusions. Unlike traditional state high-risk pools that existed before the ACA, PCIP premiums were able to vary by age but were otherwise equal to premiums paid by individuals without pre-existing conditions. In addition, there were no annual or lifetime dollar limits on covered benefits under PCIP, there were caps on out-of-pocket spending, and there was a minimum actuarial value of plans, which impacted deductibles. The ACA appropriated $5 billion to fund net losses of PCIP programs.17

While the CBO estimated in June 2010 that an average of 200,000 individuals would be enrolled in PCIP for the 2011-2013 period,18 PCIP enrollment peaked at about 115,000 in March 2013. Also in March 2013, new PCIP enrollment had to be suspended in order to ensure that there were sufficient resources to pay the claims of individuals already enrolled. Between September 2012 and September 2013, the final 12-month period for which PCIP expense data were reported, PCIP had net losses of more than $2 billion, with $4 billion in total net losses reported as of September 2013.19

Impact on Health Insurance Affordability

Mechanisms to subsidize the costs of high-risk and high-cost enrollees have had various rates of success. Concerning high-risk pools, prior to implementation of the ACA, 35 states offered high-risk pools as a mechanism to cover high-risk and high-cost residents, including those with pre-existing conditions. At their peak, state high-risk pools that existed prior to passage of the ACA covered more than 200,000 people nationally, with combined net losses for the state high-risk pools totaling more than $1.2 billion for 2011, or $5,510 per enrollee, on average. Overall, state high-risk pools featured premiums above standard non-group market rates, with most states capping them at 150 to 200 percent of standard rates. Many also featured high deductibles, including deductibles in the $5,000 range. Nineteen states had some degree of premium subsidy for low-income individuals. In addition, despite the fact that many individuals had to seek coverage in high-risk pools because of a pre-existing condition, most states excluded coverage for these conditions for medically eligible individuals ranging from six to 12 months. Almost all high-risk
pools imposed lifetime limits on covered services, with some also imposing annual limits on covered benefits. A few states capped or closed enrollment.  

The Council notes that a January 2017 report from the American Academy of Actuaries also raised concerns regarding high-risk pools, noting that “enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss… Removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-cost individuals in the individual market can incur high health care costs, which would put upward pressure on premiums.”  

The actuaries also noted that funding could be directed toward a reinsurance program that reimburses plans the costs of high-risk enrollees. For example, to fund the ACA’s transitional reinsurance program, insurers and third party administrators paid $63 per enrollee per year in 2014, $44 in 2015 and $27 in 2016. These investments in reinsurance yielded premium reductions. For example, in 2014, the $10 billion reinsurance fund, the result of the $63 per enrollee per year contributions, was estimated to reduce premiums by 10 to 14 percent. The actuaries stated that a permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums.  

Reinsurance enables high-risk enrollees to remain in the same individual market risk pool and enjoy the same protections and choices as healthy plan enrollees.  

States have also submitted waivers under Section 1332 of the ACA, as outlined in Council on Medical Service Report 1 being considered at this meeting, to fund state reinsurance programs. Alaska’s waiver, which has been approved, allows the state to implement the Alaska Reinsurance Program (ARP) for 2018 and subsequent years. The ARP will cover claims in the individual market for individuals with one or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers will relinquish both premiums received for such individuals as well as claims they would have paid absent the waiver. As a result of the ARP, it is expected that premiums will be 20 percent lower in 2018 than absent the waiver, and 1,460 additional individuals will have health insurance coverage. The waiver application of Minnesota, which has also been approved, would create the Minnesota Premium Security Plan, which was estimated to yield a 20 percent reduction in average premiums in 2018. While Minnesota’s waiver was approved, the full amount the state requested in its waiver for federal pass-through funding to financially support its reinsurance program was not approved. Only federal pass-through funding reflecting savings from less spending on premium tax credits and cost-sharing reductions was approved, not the amount also requested by the state that reflects federal savings due to lower premiums for plans under the state’s Basic Health Program. The waiver application of Oregon, which was still under review when this report was prepared, anticipates that its waiver to establish the Oregon Reinsurance Program will reduce premiums, including those for the second-lowest cost silver plan, by 7.5 percent in 2018 (net of the premium assessment), with an increase in enrollment in the individual market by approximately 1.7 percent in the same year.  

Maine also had an “invisible high-risk pool” that it implemented in 2011, which in functionality was more similar to a reinsurance program than a high-risk pool. The main difference between invisible high-risk pools and the more traditional approach to reinsurance as included in the ACA is that the pools identify potential high-cost individuals prospectively, versus being reimbursed retrospectively for patients who actually incur high-cost claims. As a result, some plan enrollees who end up having unpredictably costly claims may not be included in invisible high-risk pools, and as such insurers would not be reimbursed for a portion of their claims. For example, under Maine’s program, all health insurance applicants were required to complete a health statement with their application for insurance, and insurers used the statement to ascertain which individuals to place in the invisible high-risk pool, based on what health conditions they had. Selected individuals
were enrolled in the same plan they applied for at the same premium levels, but on the back-end, their health insurers were reimbursed for 90 percent of their claims between $7,500 and $32,500 per year and 100 percent of claims more than $32,500. Premium reductions were achieved as a result, which varied based on applicant age.26

AMA Policy Relevant to Risk Subsidization

Policy H-165.842 supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market regulation; and supports state-based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies.

Policy H-165.995 supports: (1) the establishment in each state of a risk pooling program, in which all health care underwriting entities in the state participate, to provide adequate health insurance coverage at a premium slightly higher than the standard group rate to (a) those who are unable to obtain such coverage because of medical considerations, and (b) those with medically standard risks who could afford, but presently lack, access to such group coverage; (2) the amendment of the federal tax code to require employers to purchase group health insurance coverage from an entity participating in the state risk pool or, if self-insured, to participate in the risk pool if such a pool is available, in order to deduct the cost of their coverage as a business expense; and (3) using state tax revenues as an alternative source for defraying excess pool costs.

DISCUSSION

As millions of Americans have gained coverage resulting from the ACA, the Council affirms that progress has been made on a long-time policy priority of the AMA – expanding access to affordable, quality health insurance coverage. However, in light of the health reform discussions and debates that have occurred this year, the Council believes there is an opportunity to include additional safeguards in AMA policy to ensure that patients have meaningful coverage that protects them against catastrophic expenses. While the AMA has long supported patient choice of health plan, AMA policy has also stressed that any health insurance purchased must provide meaningful coverage for hospital, surgical and medical care; protect patients against catastrophic expenses; as well as promote preventive services. AMA policy also underscores that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations, and that prohibitions on annual and lifetime limits should remain in place under any reform.

Under current law, the requirement that all qualified health plans, with the exception of grandfathered individual and employer-sponsored plans, offer at least the EHBs in the EHB package, has helped ensure that individuals have had access to meaningful coverage. Importantly, the prohibition on annual and lifetime limits, as well as the cap on out-of-pocket expenses, is only required for care that is considered to be under the umbrella of essential health benefits. Consistent with previously established AMA policy, the Council believes that using the current benchmark approach to EHBs, while requiring ten categories of essential health benefits, strikes a balance between offering meaningful coverage and maintaining patient choice in health plans and their respective benefits packages. The Council believes that the benchmark approach to EHBs recognizes that there is not a “one size fits all” approach to health insurance benefits, and that some variability is needed.
The Council notes that most of the health care claims’ costs associated with EHBs are attributable to such services as hospital inpatient and outpatient care, physician services, and prescription drugs. These services are arguably viewed as fundamental components of health insurance coverage. Removing any benefits from the EHB requirements, or allowing waivers of such requirements, can cause insurers to cherry pick patients based on the services their plans cover, as well as hinder patient access to necessary services. If insurers are allowed to offer plans with skimpier coverage, plan designs could potentially discriminate against people with pre-existing conditions. In addition, individuals who use services and benefits no longer included in the EHBs could face substantial increases in out-of-pocket costs. As such, the Council is recommending that our AMA oppose the removal of categories from the EHB package. In addition, the Council believes that our AMA should also oppose waivers of EHB requirements that lead to EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses, being eliminated.

In addition, after the expiration of the ACA’s reinsurance program, and with policymakers and stakeholders evaluating various options to improve the stability of health insurance premiums and the overall health insurance marketplace, the Council reevaluated AMA policy with respect to how to best subsidize the costs of high-cost and high-risk patients, who may have pre-existing conditions. Critics of high-risk pools as a viable option for covering high-risk individuals have emphasized that the funding allocated to them, in the past and in legislation that was considered this year, has not been sufficient. More importantly, however, is that traditional high-risk pools have provided individuals with pre-existing conditions with second-class insurance, with waiting periods to get pre-existing conditions covered, higher premiums, potentially high deductibles, and lifetime limits on benefits. As such, the Council is recommending that Policy H-165.995 be rescinded, resulting from the evidence that shows the consequences of high-risk pools, and their subjection of individuals with pre-existing conditions to a different level of health insurance. At this juncture, considering the success of the ACA’s reinsurance program, as well as state reinsurance programs, the Council believes that, considering finite resources, that resources should be directed to reinsurance programs. Reinsurance provides an equitable, fair and cost-effective mechanism to subsidize the costs of high-risk and high-cost patients, and protects patients with pre-existing conditions. The Council concludes that data suggest that a permanent reinsurance program may be a desirable policy option, whether administered at the federal or state level.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) oppose the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses. (New HOD Policy)

2. That our AMA oppose waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. (New HOD Policy)

3. That our AMA prefer reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients. (New HOD Policy)

4. That AMA Policy H-165.995 be rescinded. (Rescind HOD Policy)
Fiscal Note: Less than $500.

REFERENCES


4 Id.


8 Bayram and Dewey, supra note 2.

9 Eibner and Whaley, supra note 3.

10 Jost, supra note 6.

11 CBO, supra note 7.

12 Bayram and Dewey, supra note 2.

13 Fiedler, supra note 5.

14 Jost, supra note 6.

15 CBO, supra note 7.


19 Pollitz, supra note 17.

20 Pollitz, supra note 17.


EXECUTIVE SUMMARY

Background. This report responds to Resolution 907-I-16, “Clinical Implications and Policy Considerations of Cannabis Use” introduced by the Resident and Fellow Section and referred by the House of Delegates. Resolution 907 asked that our AMA amend existing policies.

Methods. English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from March 2013 to July 2017 using the search terms as outlined in the body of the report. The 2017 report of the National Academies of Sciences, Engineering, and Medicine (National Academies) on the health effects of cannabis and cannabinoids as well as reports developed by state agencies regarding the impact of legalizing recreational cannabis were also utilized in developing this report.

Results. The National Academies published a comprehensive report on the health effects of cannabis in January 2017. The report found conclusive or substantial evidence that cannabis or cannabinoids have some therapeutic benefits; the report also found substantial or conclusive evidence of a statistical association between cannabis smoking and health harms. The findings of a systematic review on the analgesic effects of cannabis released subsequent to the National Academies report were inconsistent with the National Academies report, which highlights the lack of agreement on this issue, and serves as a source of confusion among physicians, patients, and the public and demonstrates the need for additional research.

Legalizing the recreational use of cannabis may result in increased use over time due to changes in perceptions of safety and health risks. Existing data, although limited, have yet to confirm this pattern of use for children and adolescents. However, cannabis use has increased in adults and pregnant women. Data from jurisdictions that have legalized cannabis demonstrate concerns around unintentional pediatric exposures as well as an increase in traffic deaths due to cannabis-related impaired driving. Limited data also show a decrease in cannabis-related treatment admissions as well as a possible decrease in the use of opioids for chronic pain. Limited data suggest convictions for possession of cannabis may decline in states that legalize cannabis. States have also experienced an increase in governmental revenue through sales and excise taxes on retail cannabis.

Conclusion. The evidence available at this time does not support a substantial change in the AMA’s policy on cannabis. Ongoing surveillance to determine the impact of cannabis legalization and commercialization on public health and safety will be critical. Surveillance should include, but not be limited to the impact on patterns of use, traffic fatalities and injuries, emergency department visits and hospitalizations, unintentional exposures, exposure to second-hand smoke, and cannabis-related treatment admissions. At-risk populations, including pregnant women and children, should be a focus of attention. Continued evaluation of the effectiveness of regulations developed to ensure public health and safety in states that have legalized the medical and/or recreational use of cannabis is necessary. Jurisdictions that have legalized cannabis should allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts.
Subject: Clinical Implications and Policy Considerations of Cannabis Use (Resolution 907-I-16)

Presented by: Robert A. Gilchick, MD, MPH, Chair

Referred to: Reference Committee K (L. Samuel Wann, MD, Chair)

INTRODUCTION

Resolution 907-I-16, “Clinical Implications and Policy Considerations of Cannabis Use,” introduced by the Resident and Fellow Section and referred by the House of Delegates, asked that our AMA amend Policy H-95.998 by addition and deletion to read as follows:

H-95.998 AMA Policy Statement on Cannabis
Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale of cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and (4) additional research should be encouraged (Modify Current HOD Policy),

and amend Policy D-95.976 by deletion to read as follows:

D-95.976 Cannabis - Expanded AMA Advocacy
1. Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available. 2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research. 3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis. 4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States." (Modify Current HOD Policy)

The Council on Science and Public Health (Council) has issued four previous reports on cannabis (1997, 2001, 2009, and 2013) establishing a broad policy base. This report focuses on the health effects (both therapeutic and harmful) of cannabis and reviews available data on the impact of legalization. While the AMA prefers to use the scientific term “cannabis,” the colloquial term...
“marijuana” is used interchangeably in this report, for example, when quoting a source or identifying the official name of a committee.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from March 2013 to July 2017 using the search terms “marijuana or cannabis” in combination with “health,” “mental health,” “health effects,” “therapeutic use,” “therapeutic benefits,” “legalization,” “youth or adolescents,” “edibles,” “driving,” “taxes,” and “treatment.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations were reviewed for relevant information.

CURRENT AMA AND FEDERATION POLICY

Existing AMA policy on cannabis states that it is a dangerous drug and as such is a public health concern (H-95.998). The 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 (D-95.952). The AMA also urges that marijuana’s status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines (D-95.952). The AMA also believes that public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use (H-95.998).

The AMA believes that the sale of cannabis should not be legalized (H-95.998) and urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic, and social consequences of recreational use (D-95.976). The AMA supports requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration, “Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States” (D-95.976). The AMA also advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding (H-95.936). The AMA supports increased educational programs relating to use and abuse of alcohol, marijuana, and controlled substances (H-170.992). (see Appendix A)

Many medical societies in the Federation have taken positions that are consistent with AMA policy. The California Medical Association (CMA) is one exception. It is on record as urging the legalization and regulation of cannabis to allow for greater clinical research, oversight, accountability, and quality control. CMA believes that the most effective way to protect the public’s health is to tightly control, track, and regulate cannabis and to comprehensively research and educate the public on its health impacts, not through ineffective prohibition.

STATE LAWS ON CANNABIS

At the state level, trends in law have moved from decriminalization, to the legalization of medical use of cannabis, to cannabis regulated for adult recreational use. California was the first jurisdiction in the United States (U.S.) to legalize the medical use of cannabis. Today, 29 states, the District of Columbia (D.C.), Guam, and Puerto Rico have legalized the medical use of cannabis through either the legislative process or ballot measures. These laws vary greatly by jurisdiction from how patients access the product (home cultivated or dispensary), to qualifying conditions,
product safety and testing requirements, packaging and labeling requirements, and consumption
method (some states prohibit smoking the product). In jurisdictions that have legalized cannabis for
medicinal use, physicians can “certify” or “recommend” a qualifying patient for the medicinal use
of cannabis, but physicians cannot prescribe cannabis for medical purposes because it is illegal
under federal law. In recent years, an additional 17 states have enacted laws allowing access to low
delta-9-tetrahydrocannabinol (THC)/high cannabidiol (CBD) products for children with epilepsy.7

In 2012, Colorado (CO) and Washington (WA) were the first U.S. jurisdictions to legalize the adult
use of cannabis for recreational purposes.5,9 Today, a total of 8 states and D.C. have legalized
cannabis for recreational purposes, all through the ballot measure process.7 (Figure 1) Most of these
jurisdictions have created for-profit, commercial cannabis production and distribution markets
where the product is sold and taxed. D.C. is the exception; they have adopted a “grow and give”
model whereby residents are permitted to possess, use, grow, and give away cannabis, but they
cannot sell it.10 In 2017, legislatures in 20 states introduced legislation to legalize cannabis for
recreational use. Vermont’s legislature was the first in the country to vote in favor of legalizing
cannabis for recreational use.11 The bill was ultimately vetoed by the governor due to the lack of
provisions to protect public health and safety. Specifically, he called on policymakers to hold off
on moving forward with commercialization until the state could:

…detect and measure impairment on our roadways, fund and implement additional substance
abuse prevention education, keep our children safe and penalize those who do not, [and]
measure how legalization impacts mental health and substance abuse issues our communities
are already facing.12

RELEVANT FEDERAL LAW AND POLICY

Under the U.S. Controlled Substances Act (CSA) of 1970, cannabis is classified as a Schedule I
controlled substance, meaning it has no currently accepted medical use in treatment in the United
States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.13
In 2011, the governors of Washington and Rhode Island petitioned the Drug Enforcement
Administration (DEA) asking it to change cannabis from a Schedule I to a Schedule II drug under
the CSA. In August of 2016, the DEA announced that cannabis would remain a Schedule I
controlled substance.14 The notice stated that:

The DEA and FDA continue to believe that scientifically valid and well-controlled clinical
trials conducted under investigational new drug applications are the proper way to research all
potential new medicines, including marijuana. Furthermore, we believe that the drug approval
process is the proper way to assess whether a product derived from marijuana or its constituent
parts is safe and effective for medical use.14

Cannabis is not FDA-approved as a safe and effective drug for any indication. However, the
agency has approved three drug products containing synthetic versions of the main psychoactive
ingredient of cannabis, THC. Marinol® and Syndros™, which include the active ingredient
dronabinol, are indicated for nausea and vomiting associated with cancer chemotherapy and
anorexia associated with weight loss in patients with AIDS.15 Cesamet®, which contains the active
ingredient nabilone, also is indicated for the treatment of the nausea and vomiting associated with
cancer chemotherapy.15 Clinical investigations are underway for one CBD-based product,
Epidiolex® for Lennox-Gastaut syndrome and Dravet syndrome and the THC/CBD combination
product Sativex® for cancer pain.15,16
In 2016, the DEA announced a change in policy designed to increase the number of DEA-registered cannabis manufacturers. Currently the University of Mississippi is the only entity authorized to produce cannabis for research purposes in the United States. The new policy will allow additional entities to submit applications and become registered with the DEA to grow and distribute cannabis for FDA-authorized research purposes.17

Under the Obama Administration, a memorandum to all U.S. Attorneys outlined cannabis enforcement priorities for the federal government. The memo explained that jurisdictions enacting laws legalizing cannabis that also have strong regulatory enforcement systems would be less likely to be threatened with federal enforcement.18 Federal priorities include preventing: (1) the distribution of cannabis to minors; (2) revenue from the sale of cannabis from going to criminal enterprises, gangs, and cartels; (3) the diversion of cannabis from states where it is legal under state law in some form to other states; (4) state-authorized cannabis activity from being used as a cover or pretext for the trafficking of other illegal drugs or other illegal activity; (5) violence and the use of firearms in the cultivation and distribution of cannabis; (6) drugged driving and the exacerbation of other adverse public health consequences associated with cannabis use; (7) the growing of cannabis on public lands and the attendant public safety and environmental dangers posed by cannabis production on public lands; and, (8) cannabis possession or use on federal property.18 Accordingly, if particular conduct threatens federal priorities, that person or entity would be subject to federal enforcement actions.

While the Obama Administration tolerated state laws legalizing cannabis, it is still unclear how the Trump Administration will handle the issue.19 In July of 2017, the Attorney General sent letters to four governors warning them that he had “serious concerns” about the effects of cannabis legalization, raising questions as to whether the current compromise on enforcement with the Justice Department may be under reconsideration.20

THE HEALTH EFFECTS OF CANNABIS

The National Academies of Sciences, Engineering, and Medicine (National Academies) published a comprehensive report in January 2017 commissioned by federal, state, philanthropic, and nongovernmental organizations, entitled “The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and the Recommendations for Research.”6 The report’s recommendations outline priorities for a research agenda and highlight the potential for improvements in data collection efforts and enhanced surveillance capacity.5 The report also contained 98 conclusions based on the accumulated evidence related to cannabis or cannabinoid use and health.6 (see Appendix B)

The report examined a broad range of possible health effects of cannabis and cannabinoids. Health effects examined included those related to cancer; cardiometabolic risk; respiratory disease; immunity; injury and death; prenatal, perinatal, and neonatal exposure; psychosocial and mental health; problem cannabis use; and cannabis use and the misuse of other substances. The findings are organized into 5 evidence categories: conclusive, substantial, moderate, limited, and no/insufficient evidence. The report found conclusive or substantial evidence that cannabis or cannabinoids are effective: (1) for the treatment of chronic pain in adults (cannabis); (2) as antiemetics in the treatment of chemotherapy-induced nausea and vomiting (oral cannabinoids); and (3) for improving patient-reported multiple sclerosis spasticity symptoms (oral cannabinoids).6 The report also found substantial evidence of a statistical association between cannabis smoking and: (1) more frequent chronic bronchitis episodes (long-term cannabis smoking); (2) increased risk of motor vehicle crashes; (3) lower birth weight of offspring (maternal cannabis smoking); and
(4) the development of schizophrenia or other psychoses, with the highest risk among the most frequent users.6

A systematic review published subsequent to the National Academies report examined 27 clinical trials involving patients with chronic pain and found limited evidence that cannabis may alleviate neuropathic pain in some patients, but that insufficient evidence exists to demonstrate analgesic effects in patients with other types of chronic pain.21 This conclusion contradicts the finding of the National Academies report and is an example of how research findings on the therapeutic effects of cannabis remain inconsistent, leading to confusion among physicians, patients, the media, policy makers, and others.

IMPACT OF STATE LEGALIZATION OF CANNABIS

In 2012, CO and WA were the first states to legalize cannabis for recreational use. As jurisdictions continue to follow in their footsteps, many are looking at data from these states to determine the impact of legalization on public health and safety. Issues being examined include the impact of legalization on patterns of use by adults, children and adolescents, and pregnant women; cannabis-related exposures; cannabis-related hospital or emergency department visits; cannabis-related treatment admissions; impaired driving; crime; opioid use; and governmental costs and revenue. Since regulatory structures governing cannabis vary by jurisdiction and continue to evolve, the impact on health and safety is difficult to discern. It is also worth noting that although recreational use of cannabis was first legalized in 2012, cannabis products for recreational use were not commercially available for sale in CO or WA until 2014. Alaska (AK), D.C., and Oregon (OR) voted to legalize recreational use in 2014. While OR allowed limited sales of cannabis through medical dispensaries in 2015, cannabis dispensaries for recreational users did not open in AK or OR until 2016 (Figure 2). As a result, limited data are currently available to determine the overall impact of legalizing recreational cannabis use on specific outcome measures.

The Colorado Department of Public Health and Environment (CDPHE) appointed a Retail Marijuana Public Health Advisory Committee (RMPHAC), to review scientific literature on the health effects of cannabis and state-specific health outcomes and patterns of use.22 The RMPHAC report was informed by state-based data and national surveys such as the Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health (NSDUH) and the Center for Disease Control and Prevention’s (CDC) Behavioral Risk Factor Surveillance System (BRFSS) and Pregnancy Risk Assessment Monitoring System (PRAMS). The Washington State Institute for Public Policy (WSIPP) has conducted a benefit-cost analysis of the implementation of WA Initiative 502 as required by law.23 The Northwest High Intensity Drug Trafficking Area (NWHIDTA) and the Rocky Mountain High Intensity Drug Trafficking Area (RMHIDTA) have also issued reports on the impacts of the legalization of cannabis in WA and CO, respectively.24,25 The results from these reports were utilized in examining the impact of cannabis legalization on public health and safety.

Use among Adults

In the United States, cannabis is the most commonly used illicit drug.26 Overall, from 2002-2014, the prevalence of cannabis use during the past month, past year, and daily or almost daily increased among persons aged 18 years and older.27 In 2016, the percentage of young adults (18-25 years) who were current marijuana users (past month) was similar to the percentages in 2014 and 2015, while the percentage of older adults (≥ 26 years) who were current users continued to increase.28
The percentage of young Coloradan adults aged 18 to 25 years reporting cannabis use within the past year increased significantly after “medical” cannabis legalization (35 percent in 2007 to 2008 to 43 percent in 2010 to 2011). The latest data available suggest cannabis use has remained fairly constant in CO (45 percent in 2013-2014). In 2015, based on the BRFSS data, 13 percent of CO adults ages 18 and up had used cannabis in the past-month. The NSDUH estimate for past-month use is higher, at 17 percent. However, neither survey showed a statistical change from 2014 to 2015. According to NSDUH data, adult use of cannabis in CO has continued to be higher than the national average, which was 8 percent. In WA, young adults’ (18-25 years) past-year cannabis use was 6 percent higher than the nation’s in 2012-2013, and adults’ use (≥ 26 years) was 5 percent higher. Past month use of cannabis was 5 percent higher than the nation’s average for young adults and adults in 2012-2013. Statewide BRFSS data indicate that since the legalization of recreational cannabis in WA, use has increased among adults.

Use among Pregnant Women

Cannabis is the most commonly used illicit drug during pregnancy. The movement toward the legalization of cannabis may result in more women using cannabis during pregnancy. Cannabis crosses the placenta and is found in breast milk. It may have adverse effects on both perinatal outcomes and fetal neurodevelopment, though evidence is limited. In 2015, the American College of Obstetricians and Gynecologists issued a committee opinion discouraging physicians from suggesting the use of marijuana during preconception, pregnancy, and lactation.

Overall, cannabis use during pregnancy is increasing with 3.85 percent of pregnant women between the ages of 18 and 44 years reporting past-month cannabis use in 2014, compared with 2.37 percent in 2002. PRAMS data for CO showed that among new mothers, 11.2 percent used cannabis prior to pregnancy, 5.7 percent used cannabis during pregnancy, and 4.5 percent of breastfeeding mothers used cannabis after delivery. Cannabis use during pregnancy was statistically higher among women with an unintended pregnancy (9.1 percent) than among women who intended to become pregnant (4.0 percent). When cannabis use during pregnancy was compared among different demographics, both education and age showed statistical differences, whereas race and ethnicity did not.

Use among Adolescents

Adolescents are of particular interest in cannabis-policy discussions because the negative health effects of the drug are heightened when use begins in adolescence. In addition to the health effects, including the increased risk of addiction, evidence also suggests that cannabis use in adolescence and early adulthood is associated with poor social outcomes, including unemployment, lower income, and lower levels of life and relationship satisfaction. Changes in the legal status of cannabis may affect use among adolescents by decreasing the perceived risk of harm or through the marketing of legal cannabis. Studies examining the impact of “medical” cannabis laws found no measurable effect on the patterns of adolescent cannabis use. States with recreational or adult use cannabis laws also have not experienced an increase in adolescent use in the short term. However, further surveillance is necessary to determine long-term results.

NSDUH data for 2016 suggest that 6.5 percent or 1.6 million adolescents (12-17 years) were current (past month) users of cannabis. The percentage of adolescents who were current cannabis users in 2016 was lower than the percentages in most years from 2009 to 2014, but was similar to the percentage in 2015. In CO, estimates of current cannabis use (2002-2015) among high school students have fluctuated between approximately 20 percent and 25 percent. Survey results from 2015 indicate that approximately 38 percent of CO high school students reported having ever used
cannabis and 21 percent reported use in the past 30 days. These estimates are similar to national estimates of ever and current cannabis use among high school students. Among CO middle school students in 2015, an estimated 7.6 percent had ever used cannabis and an estimated 4.4 percent reported currently using cannabis. In WA, the Healthy Youth Survey, found that cannabis use indicators across grades 6, 8, 10, and 12, have been stable or fallen slightly since the legalization of recreational cannabis.

**Cannabis-Related Exposures**

Cannabis-related exposures generally refer to the number of human exposures related to accidental or excessive consumption or inhalation of cannabis and cannabis edibles. Early data from states that have legalized cannabis have shown an increase in calls to poison control centers related to cannabis exposures. According to the WA State Poison Control Center (WAPC), calls related to cannabis exposure nearly doubled from 2011 (n=146) to 2016 (n=286). In 2016, over 42 percent (n=120) of the total cannabis-related calls involved individuals 13-29 years of age who had been exposed to some form of cannabis. Over 70 percent (n=226) of patients were exposed to cannabis through ingestion.

In CO, 7.9 percent of adults with children 1-14 years old in the home reported having cannabis or cannabis products in or around the home (2015). It was estimated that approximately 14,000 homes in CO with children 1-14 years old had cannabis in the home with potentially unsafe storage. Cannabis-related exposures in CO increased 100 percent in the three-year average (2013-2015) since CO legalized recreational use of cannabis compared to the three-year average (2010-2012) prior to legalization. In children (≤ 5 years old), cannabis-related exposures increased 169 percent after legalization of recreational cannabis in CO. However, overall human exposures reported to Rocky Mountain Poison Center involving cannabis were marginally lower in 2016 (n=224) compared with 2015 (n=231).

A retrospective cohort study of CO children’s hospital admissions and regional poison control (RPC) cases for cannabis exposures between January 1, 2009, and December 31, 2015, found that hospital visits and RPC case rates for cannabis exposures in patients under 10 years of age increased between the 2 years prior to and the 2 years after legalization. During this time period, RPC calls increased at a significantly higher rate in CO than in the rest of the U.S. (34 percent vs. 19 percent per year). In CO, edible products were responsible for more than half of the exposures.

**Cannabis Secondhand Smoke Exposure**

For 2014 and 2015 together, 3.2 percent of adults with children 1-14 years old reported cannabis being used inside the home in CO. Of these, 83.2 percent reported the cannabis was smoked, vaporized, or dabbed (dabs are a highly concentrated extract of THC). It is estimated that approximately 16,000 homes in CO had children 1-14 years old with possible exposure to secondhand cannabis smoke or vapor in the home.

**Cannabis-Related Emergency Department Visits and Hospital Admissions**

In addition to hospitalizations for unexpected pediatric exposure to cannabis, increased cannabis use after legalization has resulted in an increase in the number of ED visits and hospitalizations related to acute marijuana intoxication. Retrospective data from the CO Hospital Association has shown that the prevalence of hospitalizations for cannabis exposure in patients aged 9 years and older essentially doubled after the legalization of medical cannabis (15 per 100,000 hospitalizations...
in 2001 to 2009 versus 28 per 100,000 hospitalizations from 2010 to 2013) and that cannabis-related ED visits nearly doubled after the legalization of recreational cannabis (22 per 100,000 ED visits in 2010 to 2013 versus 38 per 100,000 ED visits from January to June of 2014).29

Cannabis legalization may also eventually contribute to increased ED visits for the sequelae of chronic cannabis use, including cannabinoid hyperemesis syndrome.29 Patients with cannabinoid hyperemesis present to the ED with periodic bouts of intractable vomiting that are unresponsive to traditional antiemetics. CO saw a doubling of ED visits for cyclic vomiting after the legalization of medical cannabis in CO in 2009, although the total number of visits remained small.29

**Cannabis-Related Treatment Admissions**

Limited data is available regarding the impact of laws legalizing the recreational use of cannabis on cannabis-related treatment admissions,* though the early data suggests a decline in treatment admissions. A study of cannabis-related treatment admissions in Denver from 2001-2013 found that such admissions increased from 2005 (2,694) to 2008 (3,295) and then declined by 10.6 percent to 2,887 in 2011.41 Significant decreases in treatment entries after 2009, a time when access to cannabis through CO’s medical cannabis program was increasing, have been hypothesized to be a reflection of an accepting public opinion of cannabis use resulting in fewer individuals seeking treatment.41 In WA, cannabis-related treatment admissions fell in the three years following legalization of recreational use dropping from 7,843 in 2012, to 7,374 in 2013, 6,885 in 2014, and 6,142 in 2015.23 Youth treatment admissions for cannabis have remained between 66 percent and 70 percent of overall admissions in WA state since 2010.24

**Impaired Driving**

A potential unintended consequence of legalizing cannabis use for medical or recreational purposes is increased cannabis-related driving impairment. While the effects of alcohol on driving performance and crash risk are well understood, less is known regarding the effects of cannabis on driving. Research, including direct observations made in a driving simulator, has demonstrated the potential of cannabis to impair driving related skills.42-44 Individuals driving under the influence of cannabis seem to exhibit a general reckless driving style and cannabis smoking increases the risk of involvement in a motor vehicle accident approximately 2-fold.44 Cannabis use is associated with slower driving, an increased tendency to drive below the speed limit, increased following distance, increased lane weaving, and increased mean distance headway to the preceding vehicle.43 These behaviors suggest that those driving under the influence of cannabis are aware of their impairment and decrease their speed to compensate.44

Unlike alcohol, THC is not water soluble, but is stored in fatty tissues and released over time. A clear relationship between THC levels and impairment has been difficult to establish, in part, because a urine or even serum level of THC could reflect cannabis used quite remotely from the date of the specimen collection.45 Peak THC level can occur when low impairment is measured, and high impairment can be measured when THC level is low.45 Additionally, some individuals may demonstrate little or no impairment at a THC level that impairs someone else.45

The most recent data from CO show that cannabis-related traffic deaths increased 48 percent in the three-year average (2013-2015) after recreational use of cannabis was legalized compared with the three-year average (2010-2012) prior to legalization.”25 Similarly, the WA State Traffic Safety

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* Treatment admissions data as reported by substance abuse treatment facilities for inclusion in the national Treatment Episode Data Set.
Commission found that the number of drivers with THC in their blood involved in fatal driving accidents increased more than 120 percent from 2010 to 2014.\(^{24}\) Despite data from these individual states, another study found that three years after recreational cannabis legalization, motor vehicle crash fatality rates overall for WA and CO were not statistically different from those in similar states without recreational cannabis legalization.\(^{46}\)

**Legalizing Justice**

Legalizing cannabis for recreational use could have variable impacts on crime. Some have argued that legalization could result in a decrease in drug-trafficking and possession charges; others contend that the increased use of cannabis could result in increases in violent crime.

Data from WA’s Administrative Office of the Courts demonstrated that among adult offenders, misdemeanor cannabis possession convictions declined from 297 convictions in January 2012 to 0 by January 2013.\(^{23}\) Among youth offenders, misdemeanor cannabis convictions dropped from 1,015 in the first three months of 2012 to 722 in the first quarter of 2013.\(^{23}\) WA reports that from 2012 through 2014, cannabis seizure offenses reported to the National Incident-Based Reporting System decreased by nearly 62 percent.\(^{24}\) Despite the overall decline in seizures in the state, youth cannabis seizure offenses have not followed this trend. In 2010, youth twelve to seventeen years old represented 28.9 percent (n=855) of all seizures.\(^{24}\) In 2012 (legalization), they represented 37.5 percent (n=2,378) of seizures, and in 2013 they represented 68.6 percent (n=1,840) of total seizures.\(^{24}\) By the end of 2014 (commercialization), 74 percent (n=1,791) of seizures involved youth aged twelve to seventeen years.\(^{24}\)

Crime in Denver and Colorado has increased from 2013 to 2015.\(^{25}\) Since 2014, there has been an increase in organized, large-scale home grows for trafficking to states where cannabis is not legalized.\(^{25}\) Seizures of Colorado marijuana in the U.S. mail increased 471 percent from an average of 129 pounds (2010-2012) to 736 pounds (2013-2015) over the three-year period after recreational use was legalized.\(^{25}\) In addition, in Colorado, property crime increased 6.2 percent, violent crime increased 6.7 percent, and all crime increased 6.2 percent from 2014 to 2015.\(^{25}\)

**Opioid Use**

According to the Centers for Disease Control and Prevention, increases in unintentional overdoses and deaths due to prescription opioids and heroin are the biggest driver of the drug overdose epidemic. Studies have found a decrease in the use of opioids among pain patients provided with medical cannabis.\(^{47}\) Furthermore, medical cannabis laws are associated with significantly lower state-level opioid overdose mortality rates.\(^{47}\) Additional research is necessary to determine how cannabis laws may impact opioid use, morbidity, and mortality.

**Governmental Costs and Revenue**

Cannabis tax collections in CO and WA have continued to increase, and, on a national basis, legalization and associated taxation of cannabis could result in billions of dollars per year of tax revenue for states.\(^{48}\) In WA, I-502 required the WA State Liquor and Cannabis Board to oversee the recreational cannabis market and imposed a 25% excise tax on producers, processors, and retailers, which was later replaced with a 37% excise tax on retail sales.\(^{23}\) The Dedicated Marijuana Account was created for cannabis revenues and expenditures.\(^{23}\) Voters were told legalization could bring in as much as $1.9 billion over five years, with 40 percent going to the state general fund and local budgets and the remaining 60 percent intended for substance abuse prevention, research,
education, and health care. As of April 2016, state sales average over $2 million a day, which translates into mean excise tax revenue approaching $270 million per year.\textsuperscript{48} In CO, voters were initially told cannabis excise taxes would boost state revenues by $70 million per year, with the first $40 million each year to be allocated to school construction, leaving $30 million for enforcement and general state funds.\textsuperscript{48} Revenues in calendar year 2016 reached nearly $200 million. The CO legislature established a Marijuana Tax Cash Fund (MTCF) in 2014, which collects tax revenue from both medical and recreational cannabis sales. Funds in the MTCF have been appropriated to government agencies to address the possible health and safety consequences of legalization such as monitoring the health effects of cannabis, conducting health education campaigns, and providing substance abuse prevention and treatment programs.

The legalization and commercialization of cannabis results in revenue for states through taxes and fees, but it also comes with costs, both in regulating and enforcement actions and in protecting public health and safety. For example, in Colorado, the Marijuana Enforcement Division (MED) is responsible for regulating both medical and recreational cannabis businesses in the state. The MED’s four offices and 55 employees are responsible for rulemaking, licensing and inspecting cannabis-related businesses, and taking enforcement actions. The annual budget for the MED is approximately $10.5 million.

MINIMIZING HEALTH RISKS OF LEGALIZATION

As jurisdictions continue to understand the impact of legalization on health and other outcomes, the regulatory structure governing cannabis will continue to evolve. In CO, CDPHE continues to assess the knowledge gaps related to cannabis and develop policies to protect vulnerable populations.\textsuperscript{49} For example, the issue of child cannabis exposure from edibles has been concerning. In CO, confusion surrounding the serving size for edible products and the delayed onset of the effects of THC are thought to have contributed to overconsumption.\textsuperscript{49} Regulations were changed to ensure easier identification of average serving size in a single edible product.\textsuperscript{49} CO, OR and WA now require a universal symbol to be affixed to edibles. Four states (Alaska, CO, OR, and WA) prohibit the manufacture or packaging of edibles that appeal to youth.\textsuperscript{50} Concerns remain regarding the regulatory gaps that exist in each of these states and whether these regulations are actually informing consumers and keeping the public safe.\textsuperscript{50}

To address motor vehicle crashes due to driving under the influence of cannabis, some states have established per se limits for driving under the influence of cannabis. For example, CO and WA have established 5 ng/ml of THC as the legal limit for cannabis-impaired driving.\textsuperscript{49} However, little evidence exists to support the enactment of specific per se limits for cannabis.\textsuperscript{24} As a first step, states are being encouraged to conduct prevalence studies on the number and proportion of drivers testing positive for THC.\textsuperscript{24}

The Vermont Department of Health has conducted a health impact assessment to determine the potential impact of legislation to regulate and tax cannabis for recreational use on the health of Vermonters and to recommend ways to mitigate the adverse health impacts of such legislation. The recommendations include expanding all current tobacco laws to include cannabis, prohibiting the use of cannabis in public places, standardizing and testing packaging and potency, funding prevention and education, restricting advertising, prohibiting infused products on the regulated market, setting a blood level operating limit for THC, expanding screening for substance use disorders in primary care, training health care providers on the health impacts of cannabis, and funding surveillance and research.\textsuperscript{51}
CONCLUSION

Although the National Academies found conclusive or substantial evidence that cannabis or cannabinoids have some therapeutic benefits, they also found substantial or conclusive evidence of a statistical association between cannabis smoking and health harms. Furthermore, the findings of a systematic review on the analgesic effects of cannabis released subsequent to the National Academies report were inconsistent with the National Academies report, which highlights the lack of agreement on this issue, and serves as a source of confusion among physicians, patients, and the public and demonstrates the need for additional research.

Legalizing the recreational use of cannabis may result in its increased use over time due to changes in perceptions of safety and health risks. Existing data, although limited, have yet to confirm this expectation for children and adolescents. However, cannabis use has increased in adults and pregnant women. Data from jurisdictions that have legalized cannabis demonstrate concerns particularly around unintentional pediatric exposures resulting in increased calls to poison control centers and ED visits as well as an increase in traffic deaths due to cannabis-related impaired driving. Limited data also show a decrease in cannabis-related treatment admissions as well as a possible decrease in the use of opioids for chronic pain. In terms of crime, convictions for the possession of cannabis may decline in states that legalize cannabis. While states have seen an increase in revenue through sales and excise taxes on retail cannabis, the administrative and enforcement costs as well as the costs to society in terms of public health and safety should not be minimized.

Ongoing surveillance to determine the impact of cannabis legalization and commercialization on public health and safety will be critical. Surveillance should include, but not be limited to, the issues covered in this report – impact on patterns of use, traffic fatalities and injuries, emergency department visits and hospitalizations, unintentional exposures, exposure to second-hand smoke, and cannabis-related treatment admissions. There should also be a focus on at-risk populations including pregnant women and children. Continued evaluation of the effectiveness of regulations developed to ensure public health and safety in states that have legalized the medical and/or recreational use of cannabis is necessary. Jurisdictions that have legalized cannabis should allocate a substantial portion of their cannabis tax revenue for public health purposes, including substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts.

For physicians, legalization may require practice modifications, particularly regarding patient-provider conversations about use and risk. Additional education on counseling patients about the danger of second hand smoke exposure, underage use, safe storage, impaired driving, and the over-consumption of edibles may be warranted.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 907-I-16 and the remainder of this report be filed:

Cannabis Legalization for Recreational Use
Our AMA: (1) believes that cannabis is a dangerous drug and as such is a serious public health concern; (2) believes that the sale of cannabis for recreational use should not be legalized; (3) discourages cannabis use, especially by persons vulnerable to the drug's effects and in high-risk populations such as youth, pregnant women, and women who are breastfeeding; (3) believes states that have already legalized cannabis (for medical or recreational use or both) should be required take steps to regulate the product effectively in order to protect public health and safety and that laws and regulations related to legalized cannabis use should consistently be evaluated to determine their effectiveness; (5) encourages local, state, and federal public health agencies to improve surveillance efforts to ensure data is available on the short- and long-term health effects of cannabis use; (6) supports public health based strategies, rather than incarceration, in the handling of individuals possessing cannabis for personal use. (New HOD Policy)

Cannabis Legalization for Medicinal Use
Our AMA: (1) believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs, including potential cannabis products for medical use; (2) opposes the legalization of cannabis for medicinal use through the state legislative, ballot initiative, or referendum process; (3) will develop model legislation requiring the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. This product has not been approved by the Food and Drug Administration for preventing or treating any disease process."; (4) supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws; and (5) 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. (New HOD Policy)

2. That the following new policy be adopted:

Taxes on Cannabis Products
Our AMA encourages states and territories to allocate a substantial portion of their cannabis tax revenue for public health purposes, including: substance abuse prevention and treatment programs, cannabis-related educational campaigns, scientifically rigorous research on the health effects of cannabis, and public health surveillance efforts. (New HOD Policy)

3. That Policy H-95.952, “Cannabis for Medicinal Use,” be amended by addition and deletion to read as follows:

H-95.952, “Cannabis Research for Medicinal Use”
(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 urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National
Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) 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. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. (5) Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. (Modify Current HOD Policy)

4. That Policy H-95.936, “Cannabis Warnings for Pregnant and Breastfeeding Women,” be reaffirmed. (Reaffirm HOD Policy)

5. That Policies H-95.998, “AMA Policy Statement on Cannabis,” H-95.995, “Cannabis Use,” H-95.938, “Immunity from Federal Prosecution for Physicians Recommending Cannabis,” and D-95.976, “Cannabis – Expanded AMA Advocacy,” be rescinded since they have been implemented, were duplicative of another policy, or portions were incorporated into new policies proposed in this report. (Rescind HOD Policy)

Fiscal Note: Less than $1,000
FIGURE 1
Status of State Laws on Cannabis Legalization (Source: ASTHO)

FIGURE 2
Timeline of State Recreational Cannabis Laws

- **2012**
  - CO, WA legalize recreational cannabis

- **2013**
  - CO, WA recreational cannabis sales begin

- **2014**
  - AK, DC, OR legalize recreational cannabis

- **2015**
  - OR recreational cannabis sales begin

- **2016**
  - AK recreational sales begin
  - CA, MA, ME, NV vote to legalize recreational cannabis

- **2017**
  - NV recreational sales begin

- **2018**
  - CA, MA, ME recreational sales expected to begin
REFERENCES


8 CO Amendment 64. (2012).


13 21 USC 812.

14 81 FR 53687.


17 81 FR 53846.


APPENDIX A
Existing AMA Policies Related to Cannabis

D-95.976, “Cannabis - Expanded AMA Advocacy”
1. Our AMA will educate the media and legislators as to the health effects of cannabis use as elucidated in CSAPH Report 2, I-13, A Contemporary View of National Drug Control Policy, and CSAPH Report 3, I-09, Use of Cannabis for Medicinal Purposes, and as additional scientific evidence becomes available. 2. Our AMA urges legislatures to delay initiating full legalization of any cannabis product until further research is completed on the public health, medical, economic and social consequences of use of cannabis and, instead, support the expansion of such research. 3. Our AMA will also increase its efforts to educate the press, legislators and the public regarding its policy position that stresses a "public health", as contrasted with a "criminal," approach to cannabis. 4. Our AMA shall encourage model legislation that would require placing the following warning on all cannabis products not approved by the U.S. Food and Drug Administration: "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States.” Res 213, I-14.

H-95.952, “Cannabis for Medicinal Use”
(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 urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) 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, Modified: CSAPH Rep. 3, I-09, Modified in lieu of Res. 902, I-10, Reaffirmed in lieu of Res. 523, A-11, Reaffirmed in lieu of Res. 202, I-12, Reaffirmed: CSAPH Rep. 2, I-13.

H-95.998, “AMA Policy Statement on Cannabis”
Our AMA believes that (1) cannabis is a dangerous drug and as such is a public health concern; (2) sale of cannabis should not be legalized; (3) public health based strategies, rather than incarceration, should be utilized in the handling of individuals possessing cannabis for personal use; and (4) additional research should be encouraged. BOT Rep. K, I-69, Reaffirmed: CLRPD

**H-95.995, “Cannabis Use”**


**H-95.936, “Cannabis Warnings for Pregnant and Breastfeeding Women”**

Our AMA advocates for regulations requiring point-of-sale warnings and product labeling for cannabis and cannabis-based products regarding the potential dangers of use during pregnancy and breastfeeding wherever these products are sold or distributed. Res. 922, I-15.

**H-95.938, “Immunity from Federal Prosecution for Physicians Recommending Cannabis”**

Our American Medical Association supports legislation ensuring or providing immunity against federal prosecution for physicians who certify that a patient has an approved medical condition or recommend cannabis in accordance with their state's laws. Res. 233, A-15.

**H-95.997, “Cannabis Intoxication as a Criminal Defense”**


**H-170.992, “Alcohol and Drug Abuse Education”**

Our AMA: (1) supports continued encouragement for increased educational programs relating to use and abuse of alcohol, marijuana and controlled substances; (2) supports the implementation of alcohol and marijuana education in comprehensive health education curricula, kindergarten through grade twelve; and (3) encourages state medical societies to work with the appropriate agencies to develop a state-funded educational campaign to counteract pressures on young people to use alcohol. Sub. Res. 63, I-80 Reaffirmed: CLRPD Rep. B, I-90 Reaffirmation and Reaffirmed: Sunset Report, I-00 Appended: Res. 415, I-01 Reaffirmed: CSAPH Rep. 1, A-11.
The National Academies of Sciences, Engineering, and Medicine


### EVIDENCE

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| There is **conclusive or substantial evidence** that cannabis or cannabinoids are effective: | • For the treatment for chronic pain in adults (cannabis)  
• Antiemetics in the treatment of chemotherapy-induced nausea and vomiting (oral cannabinoids)  
• For improving patient-reported multiple sclerosis spasticity symptoms (oral cannabinoids) |
| There is **moderate evidence** that cannabis or cannabinoids are effective for: | • Improving short-term sleep outcomes in individuals with sleep disturbance associated with obstructive sleep apnea syndrome, fibromyalgia, chronic pain, and multiple sclerosis (cannabinoids, primarily nabiximols) |
| There is **limited evidence** that cannabis or cannabinoids are effective for: | • Increasing appetite and decreasing weight loss associated with HIV/AIDS (cannabis and oral cannabinoids)  
• Improving clinician-measured multiple sclerosis spasticity symptoms (oral cannabinoids)  
• Improving symptoms of Tourette syndrome (THC capsules)  
• Improving anxiety symptoms, as assessed by a public speaking test, in individuals with social anxiety disorders (cannabidiol)  
• Improving symptoms of posttraumatic stress disorder (nabilone) |
| There is **limited evidence** of a statistical association between cannabinoids and: | • Better outcomes (i.e., mortality, disability) after a traumatic brain injury or intracranial hemorrhage. |
| There is **limited evidence** that cannabis or cannabinoids are ineffective for: | • Improving symptoms associated with dementia (cannabinoids)  
• Improving intraocular pressure associated with glaucoma (cannabinoids)  
• Reducing depressive symptoms in individuals with chronic pain or multiple sclerosis (nabiximols, dronabinol, and nabilone) |
| There is **no or insufficient evidence** to support or refute the conclusion that cannabis or cannabinoids are an effective treatment for: | • Cancers, including glioma (cannabinoids)  
• Cancer-associated anorexia cachexia syndrome and anorexia nervosa (cannabinoids)  
• Symptoms of irritable bowel syndrome (dronabinol)  
• Epilepsy (cannabinoids)  
• Spasticity in patients with paralysis due to spinal cord injury (cannabinoids)  
• Symptoms associated with amyotrophic lateral sclerosis (cannabinoids)  
• Chorea and certain neuropsychiatric symptoms associated with Huntington’s disease (oral cannabinoids)  
• Motor system symptoms associated with Parkinson’s disease or the levodopa-induced dyskinesia (cannabinoids)  
• Dystonia (nabiximols, dronabinol)  
• Achieving abstinence in the use of addictive substances (cannabinoids)  
• Mental health outcomes in individuals with schizophrenia or schizophreniform psychosis (cannabidiol) |

### EVIDENCE

<table>
<thead>
<tr>
<th>EVIDENCE</th>
<th>CONCLUSIONS FOR CANCER</th>
</tr>
</thead>
</table>
| There is **moderate evidence** of **no** statistical association between cannabis use and: | • Incidence of lung cancer (cannabis smoking)  
• Incidence of head and neck cancers |
| There is **limited evidence** of a statistical association between cannabis smoking and: | • Non-seminoma-type testicular germ cell tumors (current, frequent, or chronic cannabis smoking) |
| There is **no or insufficient** evidence | • Incidence of esophageal cancer (cannabis smoking) |
**EVIDENCE**

**CONCLUSIONS FOR CARDIOMETABOLIC RISK**

<table>
<thead>
<tr>
<th>Evidence to support or refute a statistical association between cannabis use and:</th>
<th>Incidence of prostate cancer, cervical cancer, malignant gliomas, non-Hodgkin lymphoma, penile cancer, anal cancer, Kaposi’s sarcoma, or bladder cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subsequent risk of developing acute myeloid leukemia/acute non-lymphoblastic leukemia, acute lymphoblastic leukemia, rhabdomyosarcoma, astrocytoma, or neuroblastoma in offspring (parental cannabis use)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Conclusions for Cardiometabolic Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is limited evidence of a statistical association between cannabis use and:</td>
<td>The triggering of acute myocardial infarction (cannabis smoking)</td>
</tr>
<tr>
<td>Ischemic stroke or subarachnoid hemorrhage</td>
<td>Decreased risk of metabolic syndrome and diabetes</td>
</tr>
<tr>
<td>Increased risk of prediabetes</td>
<td>The increased risk of acute myocardial infarction</td>
</tr>
</tbody>
</table>

**EVIDENCE**

**CONCLUSIONS FOR RESPIRATORY DISEASE**

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Conclusions for Respiratory Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is substantial evidence of a statistical association between cannabis use and:</td>
<td>Worse respiratory symptoms and more frequent chronic bronchitis episodes (long-term cannabis smoking)</td>
</tr>
<tr>
<td>Improved airway dynamics with acute use, but not with chronic use</td>
<td>Higher forced vital capacity (FVC)</td>
</tr>
<tr>
<td>Improvements in respiratory symptoms.</td>
<td>An increased risk of developing chronic obstructive pulmonary disease (COPD) when controlled for tobacco use (occasional cannabis smoking)</td>
</tr>
<tr>
<td>Hospital admissions for COPD</td>
<td>Asthma development or asthma exacerbation</td>
</tr>
</tbody>
</table>

**EVIDENCE**

**CONCLUSIONS FOR IMMUNITY**

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Conclusions for Immunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is limited evidence of a statistical association between cannabis use and:</td>
<td>A decrease in the production of several inflammatory cytokines in healthy individuals</td>
</tr>
<tr>
<td>The progression of liver fibrosis or hepatic disease in individuals with viral hepatitis C (HCV) (daily cannabis use)</td>
<td>Other adverse immune cell responses in healthy individuals (cannabis smoking)</td>
</tr>
<tr>
<td>Other adverse immune cell responses in healthy individuals (cannabis smoking)</td>
<td>Adverse effects on immune status in individuals with HIV (cannabis or dronabinol use)</td>
</tr>
<tr>
<td>Increased incidence of oral human papilloma virus (HPV) (regular cannabis use)</td>
<td></td>
</tr>
</tbody>
</table>

**EVIDENCE**

**CONCLUSIONS FOR INJURY AND DEATH**

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Conclusions for Injury and Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is substantial evidence of a statistical association between cannabis use and:</td>
<td>Increased risk of motor vehicle crashes</td>
</tr>
<tr>
<td>Increased risk of overdose injuries, including respiratory distress, among pediatric populations in U.S. states where cannabis is legal</td>
<td>All-cause mortality (self-reported cannabis use)</td>
</tr>
<tr>
<td>Occupational accidents or injuries (general, nonmedical cannabis use)</td>
<td>Death due to cannabis overdose</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evidence</th>
<th>Conclusions for Injury and Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is moderate evidence of a statistical association between cannabis use and:</td>
<td></td>
</tr>
<tr>
<td>There is no or insufficient evidence to support or refute a statistical association between cannabis use and:</td>
<td></td>
</tr>
<tr>
<td>There is limited evidence of a statistical association between cannabis use and:</td>
<td></td>
</tr>
<tr>
<td>There is no or insufficient evidence to support or refute a statistical association between cannabis use and:</td>
<td></td>
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### EVIDENCE

#### CONCLUSIONS FOR PRENATAL, PERINATAL, AND NEONATAL EXPOSURE

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Conclusion</th>
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</thead>
<tbody>
<tr>
<td>Substantial evidence of a statistical association between maternal cannabis smoking and:</td>
<td>Lower birth weight of the offspring</td>
</tr>
<tr>
<td>Limited evidence of a statistical association between maternal cannabis smoking and:</td>
<td>Pregnancy complications for the mother, Admission of the infant to the neonatal intensive care unit (NICU)</td>
</tr>
<tr>
<td>Insufficient evidence to support or refute a statistical association between maternal cannabis smoking and:</td>
<td>Later outcomes in the offspring (e.g., sudden infant death syndrome, cognition/academic achievement, and later substance use)</td>
</tr>
</tbody>
</table>

#### EVIDENCE

#### CONCLUSIONS FOR PSYCHOSOCIAL

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate evidence of a statistical association between cannabis use and:</td>
<td>The impairment in the cognitive domains of learning, memory, and attention (acute cannabis use)</td>
</tr>
<tr>
<td>Limited evidence of a statistical association between cannabis use and:</td>
<td>Impaired academic achievement and education outcomes, Increased rates of unemployment and/or low income, Impaired social functioning or engagement in developmentally appropriate social roles</td>
</tr>
<tr>
<td>Limited evidence of a statistical association between sustained abstinence from cannabis use and:</td>
<td>Impairments in the cognitive domains of learning, memory, and attention</td>
</tr>
</tbody>
</table>

#### EVIDENCE

#### CONCLUSIONS FOR MENTAL HEALTH

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial evidence of a statistical association between cannabis use and:</td>
<td>The development of schizophrenia or other psychoses, with the highest risk among the most frequent users</td>
</tr>
<tr>
<td>Moderate evidence of a statistical association between cannabis use and:</td>
<td>Better cognitive performance among individuals with psychotic disorders and a history of cannabis use, Increased symptoms of mania and hypomania in individuals diagnosed with bipolar disorders (regular cannabis use), A small increased risk for the development of depressive disorders, Increased incidence of suicidal ideation and suicide attempts with a higher incidence among heavier users, Increased incidence of suicide completion, Increased incidence of social anxiety disorder (regular cannabis use)</td>
</tr>
<tr>
<td>Moderate evidence of no statistical association between cannabis use and:</td>
<td>Worsening of negative symptoms of schizophrenia (e.g., blunted affect) among individuals with psychotic disorders</td>
</tr>
<tr>
<td>Limited evidence of a statistical association between cannabis use and:</td>
<td>An increase in positive symptoms of schizophrenia (e.g., hallucinations) among individuals with psychotic disorders, The likelihood of developing bipolar disorder, particularly among regular or daily users, The development of any type of anxiety disorder, except social anxiety disorder, Increased symptoms of anxiety (near daily cannabis use), Increased severity of posttraumatic stress disorder symptoms among individuals with posttraumatic stress disorder</td>
</tr>
<tr>
<td>No evidence to support or refute a statistical association between cannabis use and:</td>
<td>Changes in the course or symptoms of depressive disorders, The development of posttraumatic stress disorder</td>
</tr>
</tbody>
</table>

#### EVIDENCE

#### CONCLUSIONS FOR PROBLEM CANNABIS USE

<table>
<thead>
<tr>
<th>Evidence Type</th>
<th>Conclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substantial evidence that:</td>
<td>Stimulant treatment of attention deficit hyperactivity disorder (ADHD) during adolescence is not a risk factor for the development of problem cannabis use</td>
</tr>
</tbody>
</table>
• Being male and smoking cigarettes are risk factors for the progression of cannabis use to problem cannabis use
• Initiating cannabis use at an earlier age is a risk factor for the development of problem cannabis use

There is **substantial evidence** of a statistical association between:
• Increases in cannabis use frequency and the progression to developing problem cannabis use
• Being male and the severity of problem cannabis use, but the recurrence of problem cannabis use does not differ between males and females

There is **moderate evidence** that:
• Anxiety, personality disorders, and bipolar disorders are *not* risk factors for the development of problem cannabis use
• Major depressive disorder is a risk factor for the development of problem cannabis use
• Adolescent ADHD is *not* a risk factor for the development of problem cannabis use
• Being male is a risk factor for the development of problem cannabis use
• Exposure to the combined use of abused drugs is a risk factor for the development of problem cannabis use
• Neither alcohol nor nicotine dependence alone are risk factors for the progression from cannabis use to problem cannabis use
• During adolescence the frequency of cannabis use, oppositional behaviors, a younger age of first alcohol use, nicotine use, parental substance use, poor school performance, antisocial behaviors, and childhood sexual abuse are risk factors for the development of problem cannabis use

There is **moderate evidence** of a statistical association between:
• A persistence of problem cannabis use and a history of psychiatric treatment
• Problem cannabis use and increased severity of posttraumatic stress disorder symptoms

There is **limited evidence** that:
• Childhood anxiety and childhood depression are risk factors for the development of problem cannabis use

<table>
<thead>
<tr>
<th>EVIDENCE</th>
<th>CONCLUSIONS FOR CANNABIS USE AND THE ABUSE OF OTHER SUBSTANCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is <strong>moderate evidence</strong> of a statistical association between cannabis use and:</td>
<td>• The development of substance dependence and/or a substance abuse disorder for substances, including alcohol, tobacco, and other illicit drugs</td>
</tr>
<tr>
<td>There is <strong>limited evidence</strong> of a statistical association between cannabis use and:</td>
<td>• The initiation of tobacco use  • Changes in the rates and use patterns of other licit and illicit substances</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EVIDENCE</th>
<th>CONCLUSIONS FOR CHALLENGES AND BARRIERS IN CONDUCTING CANNABIS RESEARCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are several challenges and barriers in conducting cannabis and cannabinoid research, including:</td>
<td>• There are specific regulatory barriers, including the classification of cannabis as a Schedule I substance, that impede the advancement of cannabis and cannabinoid research  • It is often difficult for researchers to gain access to the quantity, quality, and type of cannabis product necessary to address specific research questions on the health effects of cannabis use  • A diverse network of funders is needed to support cannabis and cannabinoid research that explores the beneficial and harmful health effects of cannabis use  • To develop conclusive evidence for the effects of cannabis use on short- and long-term health outcomes, improvements and standardization in research methodology (including those used in controlled trials and observational studies) are needed</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The discovery of thousands of disease-related genes, aided by the mapping of the human genome, has led to medical innovations capable of dramatically improving patient-centered care and outcomes. Tens of thousands of genetic/genomic tests have been developed to screen for and diagnose diseases, tailor disease treatments, predict susceptibility to certain conditions, and inform prevention strategies. The number of targeted therapeutics capable of responding to particular genetic alterations has also increased exponentially, as have “companion diagnostics” tests that delineate which subpopulations will (or will not) benefit from particular therapeutics.

Precision medicine is a tailored approach to health care that accounts for individual variability in the genes, environment and lifestyle of each person. Physicians already practice precision medicine by managing each patient according to his or her unique symptoms, history, and preferences, but recent technological advances have vastly improved the ability to integrate genetic/genomic aspects of precision medicine into clinical practice. At the same time, new health care payment and delivery models are focused on value and require that health care services demonstrate their value to patients and the health care system as a prerequisite for payment and coverage.

Advanced bioinformatics programs are being used to generate scientific evidence of the validity of genetic/genomic tests and therapeutics and also increase understanding of many health conditions. Notably, there is considerable variability among public and private payers with regard to the evidentiary requirements for coverage of genetic/genomic precision medicine. Moreover, different insurers may review the same evidence yet reach conflicting conclusions about medical necessity and coverage of these services. The Councils initiated this joint report to provide an overview of genetic/genomic precision medicine and the current coverage and payment landscape; describe AMA policy and activity in this arena; and present policy recommendations that address inconsistencies in payment and coverage for genetic/genomic precision medicine services.
The discovery of thousands of disease-associated genes, aided by the mapping of the human genome in 2003, has led to medical innovations capable of dramatically improving patient-centered care and outcomes. As of July 2017, the National Institutes of Health’s Genetic Testing Registry (GTR®), which is a central location for voluntary submission of genetic information by providers, included information on more than 52,000 genetic/genomic tests for more than 10,000 conditions. These genetic/genomic tests help screen for and diagnose diseases, tailor disease treatments, predict susceptibility to certain conditions, and inform prevention strategies. The number of targeted therapeutics capable of responding to particular genetic alterations has also increased exponentially, as have “companion diagnostics” tests that delineate which subpopulations will (or will not) benefit from particular therapeutics.

Precision medicine is a tailored approach to health care that accounts for individual variability in the genes, environment and lifestyle of each person. Physicians already practice “precision medicine” by managing each patient according to his or her unique symptoms, medical and family history, and preferences. However, recent technological advances such as the development of large-scale biologic databases (e.g., the human genome sequence), powerful methods for characterizing patients (e.g., proteomics, metabolomics, genomics, cellular assays, and mobile health technologies), and computational tools for analyzing large sets of data have vastly improved the ability to apply precision medicine principles to patient care. Precision medicine tests, technologies and therapeutics are increasingly being adopted into clinical practice as evidence of their effectiveness grows. At the same time, new health care payment and delivery models are focused on value and require that health care services demonstrate their value to patients and the health care system as a prerequisite for payment and coverage.

The Councils initiated this joint report to provide an overview of coverage and payment for genetic/genomic precision medicine; describe AMA policy and activity in this arena; and make policy recommendations. Genetic/genomic testing is used to analyze an individual’s DNA and can confirm or rule out a suspected genetic condition or help determine an individual’s chance of developing or passing on a genetic disorder. Environmental and behavioral data are also essential components of precision medicine, but unlike genetic/genomic data, their clinical use at this time is less common and coverage options are largely undeveloped. The term “genetic/genomic” is used throughout this report to refer to tests that analyze single genes or variants (genetic tests) as well as those that analyze larger portions of the genome, including multiple variants and/or genes, and whole exome and genome sequencing (genomic tests).
BACKGROUND

Precision medicine is routinely used in several specialties, most notably oncology. Using precision oncology, patients with certain cancers undergo testing that enables physicians to molecularly characterize their tumors, and tailor chemotherapy or other targeted therapeutics based on the genetic profile of their tumors. One common example is multi-variant panel tests that determine recurrence risk and potential response to chemotherapy in certain breast cancer patients. Outside of oncology, newborn screening, a state-based program in which every newborn is tested for dozens of genetic diseases that must be treated to avoid serious morbidity, is an example of precision medicine being applied on a large scale. Revolutionary advances in precision medicine have also enabled the diagnosis of rare and difficult-to-diagnose diseases, as well as the treatment of advanced-stage cancers and rare diseases that once were not treatable.

The potential exists for genetic/genomic precision medicine to be adopted more broadly into clinical practice because of advances in the technology used to collect and analyze huge sets of data, which has enabled enhanced research into genomic causes of disease and applications to clinical practice. The amount of data created with just one genome sequence is vast, and advanced bioinformatics programs are required to glean meaningful results from it. These data are being used to generate scientific evidence of the validity of genetic/genomic tests and therapeutics and also increase understanding of many health conditions. Despite these advances and initial evidence of improved health outcomes downstream, most patients do not have access to precision medicine because most public and private health insurers do not offer coverage for genetic/genomic services unless certain clinical criteria and evidentiary standards are met. As a result, access to this next generation of clinical testing services is often limited to individuals who can and choose to pay for it themselves, which has the potential to increase health disparities. While some consumers are paying for genetic tests on their own and without supervision of their physicians, many of these tests (often referred to as direct-to-consumer tests) have little clinical validity and may not be meaningful for physicians and patients. In April 2017, the Food and Drug Administration (FDA) approved marketing of certain direct-to-consumer genetic tests. Assuring the analytical and clinical validity of all clinical tests is critical to delivering optimal care to patients because not all tests are of the same quality and usefulness. Therefore, it is incumbent on physicians as well as payers to pay close attention to evaluations of the evidence supporting their clinical use.

PAYMENT AND COVERAGE

There is considerable variability among private and public payers with regard to the evidentiary requirements for coverage of genetic/genomic tests and services. Criteria used to evaluate tests and therapeutics generally include traditional measures such as analytical validity, clinical validity, and clinical utility. Analytical validity is the accuracy of the test in detecting the specific entity it was designed to detect without implying clinical significance such as diagnosis. Clinical validity is the accuracy with which a test identifies association of a specific entity (e.g., genetic variant) with a clinical purpose such as the presence, absence, predisposition to, or risk of a specific clinical condition. “Clinical utility” is a highly subjective term that does not have a universally accepted definition. Provider organizations, including national medical specialty societies, have defined this term to ensure that physicians are able to utilize testing when it is useful to physicians and patients by informing clinical care. Payers each define the term differently, with many adopting narrow definitions that require evidence of improved health outcomes downstream and that do not encompass the full value that a particular test or therapeutic may provide to patients, their families and society as a whole, such as establishing a diagnosis, reducing spending on continued diagnostic testing, and ending uncertainty for patients and their families. Clinical utility should refer to the
ability of a test to provide information related to the care of patients and to inform treatment decisions.

Currently, there is a well-established clinical evidence base to support coverage of a broad range of genetic/genomic tests; however, newer tests, which may be less expensive but for which the clinical evidence base has not yet matured, are rapidly and continuously becoming available. Because most insurers do not have the capability to assess the evidence for each test themselves they may require third-party health technology assessments (HTAs) which are then used in conjunction with other factors to make coverage determinations. HTA companies often look for evidence based on randomized controlled trials (RCTs)—which have historically been considered the gold standard for evidence generation—or comparable studies; however, the usefulness of many new genetic tests and therapeutics cannot feasibly be demonstrated using an RCT approach and may require novel research approaches. New genetic variants are being identified so rapidly that tests may need to be altered before RCTs can be completed. For example, variants that drive tumor growth and can potentially be targeted by a therapeutic are being identified and continually added to tumor testing panels. And for rare genetic diseases, RCTs may present ethical issues, take many years to complete, or never reach sufficient sample numbers.

HTAs may also require evidence not yet available that correlates genetic/genomic tests and therapies with clinical outcomes. A small study of private-payer challenges to establishing coverage of next-generation tumor sequencing (NGTS), which enables rapid examination of large numbers of genetic tumor alterations, found that most payers understand the potential benefits of NGTS. However, a majority of payers interviewed for the study also reported that NGTS does not fit into their frameworks for medical necessity and does not meet their evidentiary standards requirements. For example, some NGTS tests identify variants for which a specific therapeutic does not yet exist or for which no clinical trials are underway. Despite the potential usefulness of knowing which variants are driving tumor growth for future clinical trials or new therapies, payers do not view such results as immediately actionable. Concerns among payers regarding implementation of NGTS and care delivery, such as the ability to effectively capture results in electronic health records and the preparedness of physicians to use the results in practice, are additional barriers to coverage.

Different types and levels of evidence are currently used to assess genetic/genomic tests, and some organizations—including the Agency for Healthcare Research and Quality, the American College of Medical Genetics and Genomics (ACMG), and the American Society of Clinical Oncology (ASCO)—evaluate available evidence and develop guidelines or recommendations for testing. AdvaMedDx—a trade association for diagnostics manufacturers—has developed a comprehensive framework for assessing the value of diagnostic tests and technologies based on four value drivers: clinical impact, non-clinical patient impact, care delivery revenue and cost impact, and population impact.

Medicare

Certain payers, including Palmetto GBA, a key Medicare contractor in the clinical testing domain, perform both a regulatory function—by requiring and assessing evidence of analytical/clinical validity—and a payer assessment of medical necessity. Medicare local coverage determinations (LCDs) regarding genetic/genomic tests have largely been developed by Palmetto GBA and then routinely adopted by other Medicare contractors in a process that has been lacking in transparency and sufficient stakeholder involvement to ensure that coverage decisions are in the best interests of patients. Several national medical specialty societies representing experts in molecular pathology have expressed serious concerns regarding the credibility of the evidence used by Palmetto GBA in
the drafting of LCDs that have denied coverage for certain genetic/genomic tests. Experts have stated that these LCDs lacked sufficient input, contradicted professional society practice guidelines, and encroached on physician clinical decision-making. As a result of the Palmetto GBA LCD process, the Centers for Medicare & Medicaid Services (CMS) does not cover many of the genetic/genomic tests that might be clinically meaningful to Medicare patients. According to the National Academies of Sciences, Engineering, and Medicine, as of April 2016, well over a thousand genetic tests had been excluded from Medicare coverage.3

Federal legislation (S. 794/H.R. 3635, “Local Coverage Determination Clarification Act”) has been introduced to improve the LCD process and enable more patients to benefit from clinically validated medical innovations. This legislation would require Medicare contractors to establish a timely and open process for developing LCDs that includes open public meetings, meetings with stakeholders, an open comment period in the development of draft coverage policies, and a description of all evidence considered when drafting and finalizing coverage determinations. The LCD legislation would also require Medicare contractors seeking to adopt another contractor’s proposal to independently evaluate the evidence needed to make a coverage determination, and would provide physicians and stakeholders a meaningful reconsideration process and options for appealing a Medicare contractor’s decision to CMS. The AMA—along with the ACMG, ASCO, American Society for Radiation Oncology, American Society for Clinical Pathology, the Association for Molecular Pathology and the College of American Pathologists—supports the LCD legislation, which is consistent with AMA policy on LCDs.

Private Insurers

Private insurer coverage determination processes are neither transparent nor standardized across payers, and the evidence used by insurers to make coverage determinations regarding genetic/genomic tests and services can be inconsistent and convoluted. Just as coverage policies differ among insurers, their evidentiary standards requirements, interpretations of those standards, and evidence review processes vary as well. As a result, different insurers may review the same evidence of the validity and utility of a particular test or service yet reach conflicting conclusions about its medical necessity and coverage.

In addition to evidence-based evaluations of a genetic/genomic test’s validity and utility, private payers often seek evidence of the service’s cost-effectiveness, recommendations in professional society consensus statements or clinical practice guidelines, and peer-reviewed studies supporting its use.4 One study examined private insurer coverage policies for cell-free DNA prenatal screening tests, which are routinely covered for high-risk pregnant women, to gain insights into payer decision-making for next-generation sequencing-based tests in general.5 Most payers in this study used analytical and clinical validity and clinical utility to evaluate the evidence, and there was some variation in how they interpreted the evidence. This study also found that payers kept abreast of new peer-reviewed studies and professional society recommendations, and updated their coverage policies accordingly.6

Research into payer coverage of BRCA1/2 tests and gene panels has found that while nearly all payers covered BRCA1/2-only tests, gene panels that include BRCA1/2 were not likely to be covered because payers sought more evidence demonstrating the panels’ clinical validity and clinical utility.7 Gene panels identify more mutations than BRCA1/2-only tests but may also uncover incidental (or secondary) findings and variants of uncertain significance.8 A study of payer-perceived challenges to covering hereditary cancer panels (HCPs) found that these panels may not be covered because they include variants or genes that have not been sufficiently studied and, as a consequence, the entire panel is considered investigational or experimental.9 The study
highlights the complexity and uncertainty of the payment landscape by noting that while insurers generally do not cover HCPs, they may pay for them if, for example, they are billed for elements of the panel they considered medically necessary, or if payment denials are successfully appealed.\textsuperscript{10} Payer policies may allow coverage of certain genetic/genomic tests and therapeutics under special circumstances or after successful appeal by physicians advocating on a patient’s behalf. Physicians routinely advocate for patient access to testing that will inform diagnosis or management of disease, as well as patient access to therapeutics needed to treat disease; however, these efforts can be unduly burdensome.

On the front end, private insurers employ prior authorization, step therapy, and other forms of utilization management to control their members’ access to certain services, including genetic/genomic testing and the treatments indicated by this testing. Utilization management requirements also involve very time-consuming processes that divert physician resources away from patient care. Prior authorization often interferes with patient care by either delaying that care or denying access to certain tests and therapeutics. Several large private insurers have established national prior authorization programs for genetic/genomic testing and will deny payment for services that have not been properly authorized or, in some cases, ordered by a geneticist or genetic counselor or carried out by insurer-approved laboratories. Some of these insurers have launched online, automated prior authorization programs for genetic/genomic testing. Certain insurers have instituted a stepwise approach to genetic/genomic testing, in which a less comprehensive test (assessing only one or a few variants or genes) must be ordered first and have inconclusive results before more comprehensive testing (sequencing of one or more entire genes or multiple variants) can be ordered. Insurers may also enforce limitations on the frequency of genetic testing, including sequencing, which is not appropriate in situations where test results may significantly change over time.

At least one large insurer requires physicians to use the insurer’s own clinical decision support tool, which may not be compatible with physicians’ EHRs and which may be viewed as potentially infringing on the clinical judgment of physicians. Certain national insurers have also instituted precertification requirements that require patients to receive pre-test genetic counseling from a board-certified genetic counselor or clinical geneticist before genetic tests can be ordered. These policies effectively reduce access to genetic testing for patients who do not have access to those professionals or are being treated by non-geneticist physicians who are fully capable of providing pre-test counseling. While AMA Policy H-480.944 supports genetic counseling, Policy H-460.902 opposes genetic testing restrictions based on specialty. A study of BRCA1/2 test cancellation rates during the periods before and after one national insurer began mandating pre-test counseling by genetic counselors or clinical geneticists found that the mandate significantly reduced patient access to testing.\textsuperscript{11}

\textbf{Cost-effectiveness}

Health care costs continue to rise despite widespread efforts to insert value into models of care delivery and benefit design. Accordingly, cost-effectiveness, affordability, and value are critical to the Councils’ discussion of precision medicine and the growing market of genetic/genomic tests and therapeutics. Although whole genome sequencing has become much more affordable than it once was, most multi-variant tests are expensive, ranging from $500 to $5000. Single gene tests may cost as low as about $100 for targeted mutation analysis (testing for one or a few variants in the gene) and approximately $500 for sequencing the entire gene.

For many genetic/genomic tests, there is widespread variability in the test’s price as well as payment and coverage for that test, which must be sorted out by ordering physicians who must also
take into account patient cost-sharing expenses. In some cases, patients may request
 genetic/genomic testing that is not covered by insurance and is instead purchased directly from a
test company at an entirely different price. Cost comparison tools (e.g., Fair Health) can be used by
patients and physicians to estimate the costs of some genetic tests and services.

More research is needed to demonstrate the cost-effectiveness and economic value of precision
medicine. A 2014 study concluded that many genetic tests are cost-effective but fewer are cost
saving. Notably, a large number of available tests have not yet been evaluated. A systematic
review of economic evaluations of genetic and pharmacogenetics tests found that only 21 percent
of pharmacogenetics tests and 12 percent of predictive genetic tests are cost saving. Reporting of
incidental/secondary findings using sequencing technologies has been found to be cost-effective in
certain circumstances but not necessarily cost saving in healthy populations unless the cost of the
sequencing is below a certain threshold.12,13,14

Genetic Discrimination and Privacy

In 2008, after 13 years of effort on the part of many advocacy organizations including the AMA,
Congress passed the Genetic Information Nondiscrimination Act (GINA) nearly unanimously. Title
I of GINA prohibits group and individual health insurers from using a person’s genetic information
determining eligibility or premiums and prohibits health insurers from requesting or requiring
that a person undergo a genetic test in order to collect genetic information on that person for
underwriting decisions. Importantly, GINA does not prohibit health insurance underwriting based
on current health status, including manifest disease of a genetic nature. Rather, it is intended to
protect individuals with a genetic predisposition to disease that has not manifested, whether or not
an individual has knowledge about that predisposition based on his or her own genetic test results
or the genetic test results or manifestation of disease in a family member. Since the enactment of
GINA, only a modest number of genetic discrimination complaints have been filed under its
provisions; in 2016, 238 cases of genetic discrimination were filed out of nearly 100,000 total
discrimination cases filed.15 It is possible that the small number of cases reflects the effectiveness
of GINA at discouraging the practice of discrimination on the basis of genetics by health insurers,
or alternatively, that discrimination is occurring but is unrecognized or unreported.

Fears about genetic discrimination have led to refusal by some to undergo genetic testing.16,17,18
This can have serious health implications for individuals for whom genetic testing would be
beneficial. Even among those who do undergo genetic testing, many withhold test results from
their physicians, and some request that their results be placed in a “shadow chart” or withheld
entirely from their medical record. Information that is not available to physicians can have
detrimental effects on patient care because treating physicians unfamiliar with the patient will have
no knowledge of genetic test results unless that information is volunteered by the patient. With
more frequent use of technologies that involve analysis of patients’ genomic information, the
potential for misuse and discrimination grows. A very important additional consideration is how
difficult it has become to maintain the privacy and security of genomic information. In October
2012, the Presidential Commission for the Study of Bioethical Issues concluded that efforts to
de-identify genetic information are exceptionally challenging and will gradually become
impossible.19 In January 2013, a group of scientists demonstrated that the genetic information
provided by individuals who had been assured anonymity could in fact be re-identified.20,21,22
Therefore, given the rapid uptake of genomic-based technologies in both the clinical setting and
outside the clinic, there is a pressing need to remain vigilant on policies that protect the privacy of
individuals’ genetic information.
Physician Education

Educating physicians about precision medicine, including genetic/genomic testing and therapeutics, presents its own unique challenges, given the rapid pace of discoveries as well as extensively documented physician time constraints. Physicians must have the knowledge and skills to integrate precision medicine into their clinical practice for obvious reasons related to professionalism and patient care, and also to effectively advocate for insurer coverage of valid and meaningful genetic/genomic tests and targeted therapeutics. From a payment perspective, physicians will likely need more time for counseling patients and to analyze and explain genetic test results, and they should be adequately paid for these services. Patients who have paid for direct-to-consumer testing may also present genetic risk factor findings to their physicians, who are then challenged to consider how to explain the test results and also justify payment for clinical follow-up. Additionally, laboratories providing the tests are increasingly requesting large quantities of documentation from physicians that are needed for retrospective reviews.

The technical complexity of precision medicine adds to the hurdles faced by physicians interested in integrating this type of care into their practices. Training and implementation costs associated with adopting new care practices must be taken into consideration. As in many areas of medicine, there is also the need for significant health information technology (health IT) improvements that will enable interoperability, access, and clinical decision support while not creating additional burdens and usability challenges for physicians.

AMA ACTIVITY

In recent years, the AMA House of Delegates has established relevant policies recommended by the councils. The Council on Science and Public Health (CSAPH) has addressed several topics related to precision medicine including genome editing (CSAPH Report 3-I-16), genomics in hypertension (CSAPH Report 1-I-14), genomics in type 2 diabetes (CSAPH Report 2-A-14), genetic discrimination (CSAPH Report 7-A-13), and next-generation genomic sequencing (CSAPH Report 4-I-12). CSAPH Report 3-A-16 discusses the Precision Medicine Initiative (PMI), now called the All of Us initiative, which is creating a research cohort of over one million volunteers who will share their genetic, environmental and lifestyle data.

The Council on Medical Service developed Report 2-A-13 on value-based insurance design; Report 7-A-14 on coverage and payment for telemedicine; Report 5-I-16 on incorporating value into pharmaceutical pricing; and Report 6-I-16 on integrating mobile health applications and devices into clinical practice.

Regulatory Activity

Uncertainties in the oversight and regulation of genetic/genomic testing services have the potential to stifle innovation and impede patient access to what could be transformative, life-altering care. The AMA, in collaboration with several national medical specialty societies, has developed legislative principles to guide its advocacy efforts in this arena. The principles make clear that payment and coverage policies should not dictate which diagnostic or treatment options are available to physicians and patients, and should take into account the role of physicians in driving and applying genetic/genomic innovations. Furthermore, the principles reinforce that testing alone will not dictate treatment. Rather, physicians’ diagnostic impressions and their interpretation of test results in the context of the patient’s clinical situation and preferences should guide treatment options. Since regulation of
genetic tests is integral to physician practice and patient care, the AMA is engaged in ongoing
advocacy with policymakers and other stakeholders to preserve the physician’s role in all aspects
of patient care, including the oversight of laboratory-developed tests and other components of
precision medicine.

The AMA actively supports a Clinical Laboratory Improvement Amendments (CLIA)-based
laboratory oversight system along with appropriate third-party accreditation, and is opposed to
FDA oversight of laboratory-developed testing services in all but the most narrow of
circumstances. Accordingly, the AMA has made public comments and statements opposing FDA
oversight activities that infringe on the practice of medicine, and is engaged with a broad group of
stakeholders to support regulatory reform for genetic tests that promotes innovation and preserves
patient access. The AMA has also urged Congress to pursue modernization of the CLIA oversight
framework for high complexity laboratory testing services that would establish standards for
clinical validity and strengthen established standards related to quality control and quality
assurance, and to personnel standards including regular proficiency testing. Strengthening the
existing CLIA oversight framework will assure patient safety and provide a stronger structure to
prevent laboratory errors while preserving patient access to care.

Protecting Access to Medicare Act (PAMA)

Section 216 of the Protecting Access to Medicare Act (PAMA), which was enacted in 2014,
significantly revised the Medicare payment system for clinical tests by requiring that Medicare
payment for laboratories be based on the weighted median of private payer rates. Regulations
issued by CMS in June 2016 required laboratories that provide clinical testing, including certain
physician office-based laboratories, to collect and report private payer payment and test volume
data to CMS. CMS is using this private payer data to set new payment rates that will become
effective on January 1, 2018.

The AMA has urged CMS to implement a number of measures to ensure the accuracy of the new
payment rates, which will be based on a retrospective reporting period for data collection from
2016. The AMA has expressed serious concerns to CMS regarding the integrity of the data that will
be used to calculate the new payment rates, and whether the rates will accurately reflect the
weighted median of private payer payments, as Congress intended. Based on the lack of data
integrity, the AMA and other stakeholders anticipate that the new payment rates could effectively
reduce patient access to clinical lab testing. The AMA also continues to urge CMS to ensure that
implementation of the new payment rates results in as little administrative burden for physicians as
possible.

PAMA regulations also required CMS to issue Healthcare Common Procedure Coding System
(HCPCS) codes to identify new advanced diagnostic laboratory tests (ADLTs), and clinical tests
that are cleared or approved by the FDA (referred to as Clinical Diagnostic Laboratory Tests, or
CDLTs), if an applicable Current Procedural Terminology (CPT) code (HCPCS level I) does not
exist; and to provide, upon request, either a HCPCS code or unique identifier for test tracking and
monitoring. In order to address these coding provisions, the CPT Editorial Panel approved in
November 2015, and finalized at its February 2016 panel meeting, the new Proprietary Laboratory
Analyses (PLA) section of the CPT code set. PLA codes include a descriptor for laboratories or
manufacturers that want to more specifically identify their tests. An important part of the
development of this new set of codes is that industry and other stakeholders, including subject
matter experts, actively participate in the PLA process. To that end, the Panel created the
Proprietary Laboratory Analyses Technical Advisory Group (PLA-TAG) to advise the Panel on
applications received for codes to be added to the PLA section of CPT. Along with representation
by the Panel and certain Panel workgroups, the PLA-TAG is composed of individuals with
expertise relating to the services covered under the CPT PLA section. These include, but are not
limited to, members from various industry segments such as independent laboratories, private
payers, professional/industry organizations, commercial laboratories, academic medical institutions
and private practitioners. Members of the PLA-TAG will play a crucial role in the PLA code
creation process by reviewing CPT PLA code change applications and making recommendations
regarding these requests for CPT codes that describe ADLTs or CDLTs.

Prior Authorization

Due to its widespread usage and the significant administrative and clinical concerns it can present,
the AMA addresses prior authorization through a multifaceted approach that includes a number of
high-profile activities, including the release of Prior Authorization and Utilization Management
Reform Principles to address priority concerns. The principles were developed by a workgroup of
state and national medical specialty societies, national provider associations and patient
representatives convened by the AMA. The 21 principles (https://www.ama-assn.org/sites/default/files/media-browser/principles-with-signatory-page-for-slsc.pdf) seek to
improve prior authorization and utilization management programs by addressing broad categories
of concern including: clinical validity; continuity of care; transparency and fairness; timely access
and administrative efficiency; and alternatives and exemptions. Health plans, benefit managers and
any other parties conducting utilization management, as well as accreditation organizations, have
been urged to apply the principles to both medical and pharmacy benefits. The principles, which
have gained widespread support since their release, with over 100 stakeholder organizations
signing on in support of their objectives, include the following:

- Any utilization management program applied to a service, device or drug should be based on
  accurate and up-to-date clinical criteria and never cost alone. The referenced clinical
  information should be readily available to the prescribing/ordering provider and the public.
- Utilization management programs should allow for flexibility, including the timely overriding
  of step therapy requirements and appeal of prior authorization denials.
- Utilization review entities should offer an appeals system for their utilization management
  programs that allows a prescribing/ordering provider direct access to a provider of the same
  training and specialty/subspecialty for discussion of medical necessity.

The AMA has also engaged in two research projects to gather data on the impact of prior
authorization on patients and physician practices. A web-based survey of 1000 practicing
physicians conducted with a market research partner in December 2016 found that practices
complete an average of 37 prior authorizations per physician per week, which take the physician
and his/her staff an average of 16 hours—the equivalent of two business days—to process. Ninety
percent of physicians reported that prior authorization delays patients’ access to necessary care.
for the aforementioned principles and have provided a strong evidence base for AMA advocacy
efforts related to prior authorization. The AMA is also partnering on an academic research project
seeking to measure the overall impact of prior authorization on health care costs and outcomes.

The AMA also works closely with state medical associations and national medical specialty
societies to address prior authorization and other utilization management issues through state
legislation. Several bills passed by state legislatures have been based on the AMA’s model
legislation, the “Ensuring Transparency in Prior Authorization Act” (https://www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/model-bill-ensuring-
transparency-in-prior-authorization.pdf). The AMA’s Prior Authorization Toolkit (https://www.ama-assn.org/system/files/media-browser/premium/psa/prior-authorization-toolkit_0.pdf) provides a useful overview of the current prior authorization landscape and tips for reducing practice burdens related to prior authorization, including implementation of standard electronic processes. In sum, prior authorization and other utilization management programs are high-priority targets for the AMA.

**Educating Physicians**

The AMA recognizes the importance of educating physicians and physicians-in-training about the clinical uses and ethical considerations of genetic/genomic services. To assist physicians who are encountering new precision medicine technologies, the AMA has partnered with Scripps Translational Science Institute and The Jackson Laboratory to develop “Precision Medicine for Your Practice“ (http://education.ama-assn.org/precision-medicine.html), a series of short, online continuing medical educational modules covering specific topics in genomics and precision medicine, including expanded carrier screening in prenatal care, prenatal cell-free DNA screening, somatic cancer panel testing, large scale sequencing in the healthy individual, large scale sequencing as a diagnostic tool, and pharmacogenomics. In the near future, the AMA will be adding modules on sequencing the healthy individual, pharmacogenomics and neurogenomics.

Additionally, the AMA is carrying out research to identify physicians’ educational and resource needs for appropriate implementation of precision medicine into practice. The AMA will continue to develop tools to assist physicians with precision medicine needs.

**AMA and All of Us Initiative**

As part of its pledge to assist with the PMI, which includes the All of Us Research Program, the AMA is committed to actively working to improve patient access to personal medical information and helping physicians leverage electronic tools to make health information more readily available; developing and disseminating resources including toolkits, podcasts and fact sheets; and improving awareness of the PMI/All of Us Initiative, and how to enroll in its cohort, among physicians.

**Health IT and Digital Health**

Significant improvements in EHR and other health IT capabilities are critically needed for precision medicine to reach its potential. Robust and interoperable health IT systems must be able to access and display longitudinal health data from each patient regardless of where the data is stored. EHRs are rich with biological, behavioral and environmental data; however, impediments to accessing and enabling the secure exchange of data across health care systems must be overcome. Clinical decision support that will enable application of the data to care management is also an essential component; however, many EHR systems in use today do not have such capabilities, and physicians are frustrated with the usability of EHR systems and report that they sometimes hamper safe and effective care. The AMA actively promotes EHRs that can provide clinical decision support and use genetic/genomic data to provide clinically meaningful information to physicians.

Beyond EHRs, the AMA is committed to understanding and influencing the evolution of health IT and digital health, both of which are integral to the implementation of precision medicine. The AMA provides leadership on digital solutions involving telemedicine and telehealth, mobile health, wearables, and remote monitoring. Using the expertise of physicians and input from partners on the leading edge of health technology, the AMA has developed resources, toolkits and training to help physicians navigate and maximize technology for improved patient care.
AMA POLICY

Policy H-460.908 acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care; calls for the development of educational resources and tools to assist in the clinical implementation of genomic-based personalized medicine; and directs the AMA to continue to represent physicians’ voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information. Policy D-460.968 supports the AMA’s work with the PMI and also advocates for improvements to electronic health record systems that will enable interoperability and access without creating additional burdens and usability challenges for physicians.

Policy D-460.976 directs the AMA to maintain a visible presence in genetics and molecular medicine. Policy H-480.944 supports appropriate use of genetic testing, pre- and post-test counseling for patients undergoing testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists, as well as the development of best practice standards concerning pre- and post-test genetic counseling. Under Policy H-460.902, the AMA opposes limiting the ordering of genetic testing based solely on physician specialty. The clinical application of next generation genomic sequencing is addressed by Policy H-460.905, while genome analysis and variant identification is the subject of Policy D-460.971. Policy D-480.987 focuses on direct-to-consumer marketing and availability of genetic tests, and recommends that genetic testing be carried out under the supervision of a qualified health professional. Policy H-65.969 strongly opposes discrimination based on genetic information.

Policy H-185.939 supports flexibility in the design and implementation of value-based insurance design (VBID), which explicitly considers the clinical value of a given service or treatment when determining cost-sharing structures or other benefit design elements. Policy H-185.939 calls for active involvement of practicing physicians; the use of high-quality, evidence-based data; and transparency of the methodology and criteria used to determine high- or low-value services or treatments and coverage and cost-sharing policies. The policy states that VBID should not restrict access to patient care and must include an appeals process to enable patients to secure care recommended by their physicians. The policy also calls for plan sponsors to engage in ongoing evaluation of the plan designs to ensure VBID coverage rules are updated in accordance with evolving clinical evidence.

AMA policy promotes price transparency and education regarding cost-sharing by health plans (Policies D-155.987 and H-165.828). Policy H-320.949 states that utilization management criteria should be based on sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. Policy D-330.908 advocates for improvements in the LCD process, including increased transparency and a prohibition on Medicare contractors adopting another contractor’s LCD without a full and independent review. Policy D-330.918 directs the AMA to work with national medical specialty societies and CMS to identify outdated coverage decisions that create obstacles to clinically appropriate patient care. Policy H-460.909 outlines principles for comparative effectiveness research, and Policy D-390.961 advocates for adequate investment in this type of research and also better methods of data collection, development, reporting and dissemination of practical clinical decision-making tools. Policy H-155.960 promotes value-based decision-making, collection of clinical and cost data, and cost-effectiveness research, while principles to guide value-based decision-making are delineated in Policy H-450.938.
DISCUSSION

The Councils’ work on precision medicine is timely given passage of the 21st Century Cures Act and continued funding of the PMI, including the All of Us Research Program, and the Cancer Moonshot. The speed and volume of advances in genetics and genomics are impacting an array of regulatory, coding and payment processes that remain very fluid and will continue to be closely monitored by the AMA so that the physician perspective is clearly articulated. As with past health care innovations, the initial period of implementation of genetic/genomic precision medicine is complex and costly. Payers, policymakers and other stakeholders are challenged to keep up with the rapid development of new tests and technologies and the generation of evidence supporting their use, which are essential to ensuring patient safety while also preventing delays in payment and coverage for valid and meaningful services. In the long run, the Councils anticipate that genetic/genomic precision medicine services will become more affordable and in the mainstream across a variety of medical specialties.

The Councils’ recommendations build upon existing AMA policy to establish new, foundational policy addressing the inconsistencies in payment and coverage of genetic/genomic precision medicine services. The Councils recommend reaffirmation of seven integral policies: Policy H-460.968, which directs the AMA’s work on the PMI; Policy H-460.908, which directs the AMA to continue engaging in policy discussions related to the clinical implementation of genetics/genomics; Policy D-480.987, which focuses on direct-to-consumer marketing and availability of genetic testing; Policy H-185.939, which supports implementation of value-based insurance design, consistent with a series of principles regarding the clinical value of treatments and services; Policy H-329.949, which focuses on utilization management-related barriers to care; Policy H-65.969, which opposes discrimination based on genetic information; and Policy H-460.902, which opposes limitations by payers on the ordering of genetic testing based solely on physician specialty.

The Councils discussed the importance of sharing genomic variant data and ensuring that patients and physicians are notified of clinical significance changes. The Councils recommend adding a third clause to Policy D-460.971, which would encourage laboratories to establish a process by which patients and their physicians could be notified when interpretation and clinical significance changes for previously reported variants.

The Councils are concerned by the lack of transparency and standardization across payer coverage determination processes, which may hinder access to valid and meaningful tests and therapeutics as well as future innovations. Accordingly, the Councils recommend that the AMA encourage public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that promote transparency and clarity; involve stakeholders across disciplines, including genetic/genomic medicine experts; describe the evidence being considered and methods for updating the evidence; provide opportunities for comment and meaningful reconsiderations; and incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole.

The Councils further recognize that the usefulness of many new genetic tests and therapeutics cannot feasibly be demonstrated using an RCT approach and will require novel research approaches. Accordingly, the Councils recommend that the AMA encourage coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through RCTs, and work with test developers to establish clear thresholds for acceptable evidence for coverage.
Because patient access to genetic/genomic precision medicine services is largely dependent on public and private insurer decisions to pay for them, the Councils recommend that the AMA work with national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics.

As additional steps toward timely and appropriate application of precision medicine into practice, the Councils recommend that the AMA encourage national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services; and support continued research and evidence generation demonstrating the validity, meaningfulness, cost-effectiveness and value of precision medicine.

Finally, the Councils recognize that the payment and coverage landscape for precision medicine is evolving, and emphasize that the Councils’ work is ongoing. Future studies may be warranted by further innovation and as new technologies—such as artificial intelligence—are adopted into clinical practice.

RECOMMENDATIONS

The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-460.968, which directs the AMA to work with the Precision Medicine Initiative, develop resources for physicians on this initiative, and continue to advocate for improvements to electronic health record systems that will enable interoperability and access while not creating additional burdens and usability challenges for physicians. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-460.908, which directs our AMA to continue representing physicians in policy discussions of issues related to the clinical implementation of genomic-based medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-480.987, which recommends that genetic testing be carried out under the supervision of a qualified health professional; encourages individuals interested in obtaining genetic testing to contact a qualified health professional; and directs the AMA to educate and inform physicians on the types of genetic tests available directly to consumers. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-185.939, which supports flexibility in the design and implementation of value-based insurance design programs consistent with a series of principles regarding the clinical value of treatments and services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-329.949, which states that utilization management criteria should be based on sound clinical evidence, permit variation to account for individual patient differences, and allow physicians to appeal decisions. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-65.969, which strongly opposes discrimination based on an individual’s genetic information; support legislation that protects against genetic discrimination and misuse of genetic information; and supports education for health care providers and
patients on the protections against genetic discrimination currently afforded by federal and state laws. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-460.902, which opposes limitations by public and private payers on the ordering of genetic testing that are based solely on physician specialty. (Reaffirm HOD Policy)

8. That our AMA modify Policy D-460.971 by addition and deletion to read as follows:

Our AMA: (1) encourages payers, regulators and providers to make clinical variant data and their interpretation publicly available through a system that assures patient and provider privacy protection; and (2) encourages laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results, into the public domain which would allow appropriate interpretation and surveillance for these variations that can impact the public's health; and (3) encourages laboratories to establish a process by which patients and their physicians could be notified when interpretation and clinical significance changes for previously reported variants. (Modify Current HOD Policy)

9. That our AMA encourage public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that:
   a. Promote transparency and clarity;
   b. Involve multidisciplinary stakeholders, including genetic/genomic medicine experts and relevant national medical specialty societies;
   c. Describe the evidence being considered and methods for updating the evidence;
   d. Provide opportunities for comment and review as well as meaningful reconsiderations; and
   e. Incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival. (New HOD Policy)

10. That our AMA encourage coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through randomized controlled trials, and work with test developers and appropriate clinical experts to establish clear thresholds for acceptable evidence for coverage. (New HOD Policy)

11. That our AMA work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics. (New HOD Policy)

12. That our AMA encourage national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services. (New HOD Policy)

13. That our AMA support continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES

4 Id.
6 Id.
8 Id.
10 Id.
Introduced by: American Academy of Pain Medicine

Subject: Protection of Physician Freedom of Speech

Referred to: Reference Committee on Amendments to Constitution and Bylaws
(Edmund R. Donoghue, Jr., MD, Chair)

Whereas, Physicians have a First Amendment right to express their good faith views on medical therapies and other medical issues; and

Whereas, Physicians’ rights to express their good faith views on medical issues should not be lost because those views are expressed at seminars or other programs at which the physicians are paid by the sponsor; and

Whereas, Physicians have been, and increasingly are being, sued for doing nothing more than expressing their views on such topics as use of opioids in treating chronic pain and use of marijuana for medical treatment purposes; and

Whereas, Lawsuits challenging the expression of a physician’s opinion on medical issues are often directed against key opinion leaders in the particular medical specialty; and

Whereas, The defense of cases in which physicians are sued for expressing their good faith views on medical issues can be very expensive, can cost more than the available insurance coverage, can cause significant anxiety, and can divert the defendant physicians from their practices; and

Whereas, The mere bringing of these types of suits will exert a chilling effect on the willingness of physicians to speak out in good faith on such controversial issues as a woman’s right to choose termination of pregnancy, treatment of Attention Deficit Disorder, the role of marijuana in medical treatment, use of opioids to treat chronic pain, and the efficacy of annual mammograms and PSA screening; therefore be it

RESOLVED, That our American Medical Association strongly oppose litigation challenging the exercise of a physician’s First Amendment right to express good faith opinions regarding medical issues (New HOD Policy); and be it further

RESOLVED, That our AMA’s House of Delegates encourage the AMA Litigation Center to provide such support to a constituent or component medical society whose members have been sued for expressing good faith opinions regarding medical issues as the Litigation Center deems appropriate in any specific case. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/11/17
References:

Luberda v. Purdue Frederick Corp Civil Action No 4:13-cv-00897 S District Court D. So Carolina, Florence Division, filed 4/3/13 (physicians expressing their views on the utilization of opioid medications in the treatment of chronic pain)

County of Suffolk v PurduePharma et al, State of New York Supreme Court Index# 613760/2016; filed 8/31/16 and numerous similar cases brought separately by different counties in New York (physicians expressing their views on the utilization of opioid medications in the treatment of chronic pain)

City of Lorain (Ohio) v. PurduePharma et al, Ohio Northern District Court Case #: 1:17-cv-01639, filed 8/4/17 (physicians expressing their views on the utilization of opioid medications in the treatment of chronic pain)

Conant v. Walters, 309 F.3d 629 (9th Cir. 2002), filed 9/7/00 (advocacy of use of marijuana for medical treatment purposes).
Whereas, The First Amendment of the U.S. Constitution states that “Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the government for a redress of grievances;” and

Whereas, There are over 3 billion active social media users around the world; and

Whereas, Studies indicate that Internet usage by physicians now exceeds 80% for professional communication, research, and networking; and

Whereas, Physicians have been disciplined or terminated by employers for expressing their personal viewpoints using their personal social media accounts; and

Whereas, AMA has existing policy that outlines the right of physicians to advocate for change in law and policy, in the public arena, and within their institutions; therefore be it

RESOLVED, That our American Medical Association encourage the Council on Ethical and Judicial Affairs to amend Ethical Opinion 1.2.10, “Political Action by Physicians,” by addition to read as follows:

E-1.2.10 Political Action by Physicians

Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients and community health. However, they have a responsibility to do so in ways that are not disruptive to patient care. Physicians who participate in advocacy activities should:

(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.

(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.

(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians’ primary and overriding commitment to patients.
(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

Furthermore, physicians:
(e) Should indicate they are expressing their personal opinions, which are guaranteed under the First Amendment of the U.S. Constitution, and should refrain from implying or stating that they are speaking on behalf of their employers;
(f) Should be allowed to express their personal opinions publicly without being subjected to disciplinary actions or termination. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 10/12/17

References:
Physicians and the First Amendment

RELEVANT AMA POLICY

E-1.2.10 Political Action by Physicians
Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law or policy are contrary to the best interests of patients. However, they have a responsibility to do so in ways that are not disruptive to patient care.

Physicians who participate in advocacy activities should:
(a) Ensure that the health of patients is not jeopardized and that patient care is not compromised.
(b) Avoid using disruptive means to press for reform. Strikes and other collection actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.
(c) Avoid forming workplace alliances, such as unions, with workers who do not share physicians primary and overriding commitment to patients.
(d) Refrain from using undue influence or pressure colleagues to participate in advocacy activities and should not punish colleagues, overtly or covertly, for deciding not to participate.

E-2.3.4 Political Communications
Physicians enjoy the rights and privileges of free speech shared by all Americans. It is laudable for physicians to run for political office; to lobby for political positions, parties, or candidates; and in every other way to exercise the full scope of their political rights as citizens. Physicians may exercise these rights individually or through involvement with professional societies and political action committees or other organizations.

When physicians wish to express their personal political views to a patient or a patients family, the physician must be sensitive to the imbalance of power in the patient-physician relationship, as well as to the patients vulnerability and desire for privacy. Physicians should refrain from initiating political conversations during the clinical encounter.

Physicians must not allow differences with the patient or family about political matters to interfere with the delivery of professional care.

When expressing political views to a patient or a patients family, physicians should:
(a) Judge both the intrusiveness of the discussion and the patients level of comfort before initiating such a discussion.
(b) Discuss political matters only in contexts where conversation with the patient or family about social, civic, or recreational matters is acceptable.
(c) Refrain from conversation about political matters when the patient or family is emotionally pressured by significant medical circumstances.
(d) Work towards and advocate for the reform and proper administration of laws related to health care. Physicians should stay well informed of current political questions regarding needed and proposed reforms.

(e) Stay well informed about needed or proposed policies concerning health care access and quality, medical research, and promoting public health so as to be able to advocate for patients' needs.

**Free Speech Applies to Scientific Knowledge H-460.895**
Our AMA will advocate that scientific knowledge, data, and research will continue to be protected and freely disseminated in accordance with the U.S. First Amendment.

Citation: Res. 228, A-17

**Government Interference in Patient Counseling H-373.995**

1. Our AMA vigorously and actively defends the physician-patient-family relationship and actively opposes state and/or federal efforts to interfere in the content of communication in clinical care delivery between clinicians and patients.
2. Our AMA strongly condemns any interference by government or other third parties that compromise a physician's ability to use his or her medical judgment as to the information or treatment that is in the best interest of their patients.
3. Our AMA supports litigation that may be necessary to block the implementation of newly enacted state and/or federal laws that restrict the privacy of physician-patient-family relationships and/or that violate the First Amendment rights of physicians in their practice of the art and science of medicine.
4. Our AMA opposes any government regulation or legislative action on the content of the individual clinical encounter between a patient and physician without a compelling and evidence-based benefit to the patient, a substantial public health justification, or both.
5. Our AMA will educate lawmakers and industry experts on the following principles endorsed by the American College of Physicians which should be considered when creating new health care policy that may impact the patient-physician relationship or what occurs during the patient-physician encounter:
   A. Is the content and information or care consistent with the best available medical evidence on clinical effectiveness and appropriateness and professional standards of care?
   B. Is the proposed law or regulation necessary to achieve public health objectives that directly affect the health of the individual patient, as well as population health, as supported by scientific evidence, and if so, are there no other reasonable ways to achieve the same objectives?
   C. Could the presumed basis for a governmental role be better addressed through advisory clinical guidelines developed by professional societies?
   D. Does the content and information or care allow for flexibility based on individual patient circumstances and on the most appropriate time, setting and means of delivering such information or care?
   E. Is the proposed law or regulation required to achieve a public policy goal - such as protecting public health or encouraging access to needed medical care - without preventing physicians from addressing the healthcare needs of individual patients during specific clinical encounters based on the patient's own circumstances, and with minimal interference to patient-physician relationships?
   F. Does the content and information to be provided facilitate shared decision-making between patients and their physicians, based on the best medical evidence, the physician's knowledge and clinical judgment, and patient values (beliefs and preferences), or would it undermine shared decision-making by specifying content that is forced upon patients and physicians without regard to the best medical evidence, the physician's clinical judgment and the patient's wishes?
   G. Is there a process for appeal to accommodate individual patients' circumstances?

6. Our AMA strongly opposes any attempt by local, state, or federal government to interfere with a physician's right to free speech as a means to improve the health and wellness of patients across the United States.

Citation: Res. 201, A-11; Reaffirmation: I-12; Appended: Res. 717, A-13; Reaffirmed in lieu of Res. 5, I-13; Appended: Res. 234, A-15
Whereas, The American Medical Association has numerous and extensive policy on electronic health records (EHRs) that support current advocacy efforts to improve EHRs and advance health information technology (HIT); and

Whereas, This body of existing policy has helped the AMA make progress in persuading policymakers and other stakeholders that greater attention is needed on issues such as flexibility, EHR usability, and security; and

Whereas, While AMA policy on HIT continues to guide current and ongoing efforts, the AMA’s fundamental principles on information technology have never been codified in their entirety as AMA policy; and

Whereas, Clear and concise principles should be set forth to outline what HIT should seek to accomplish and give voice to what physicians feel is missing from current technology-enabled solutions; therefore be it

RESOLVED, That our American Medical Association adopt and promote the development of effective electronic health records in accordance with the following health information technology principles:

1. Whenever possible, physicians should have direct control over choice and management of the information technology used in their practices.

2. Information technology available to physicians must be safe (e.g., electronically secure, and in the case of distributed devices, physically so), effective and efficient.

3. Information technology available to physicians should support the physician’s obligation to put the interests of patients first.

4. Information technology available to physicians should support the integrity and autonomy of physicians.

5. Information technology should support the patient’s autonomy by providing access to that individual’s data.

6. There should be no institutional or administrative barriers between physicians and their patients’ health data.

7. Information technology should promote the elimination of health care disparities.

8. The cost of installing, maintaining and upgrading information technology should be specifically acknowledged and addressed in reimbursement schedules on an ongoing basis; payments should ensure sustainability of such systems in practice.

(Fiscal Note: Modest - between $1,000 - $5,000.)

Received: 10/02/17
RELEVANT AMA POLICY

National Health Information Technology D-478.995

1. 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.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians’ practices; and (B) develop minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology’s (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

Information Technology Standards and Costs D-478.996

Our AMA will:

(1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems;

(2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices;

(3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems;

(4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and

(5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

Principles for Hospital Sponsored Electronic Health Records D-478.973

1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).

2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.

3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.

4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.
WHEREAS, Physician practices acquire EMR systems which have demonstrated the technological capability, functionality, and security requirements required by the Secretary of Health and Human Services and have received certification by the Office of the National Coordinator; and

WHEREAS, Acquisition of the hardware and EMR software are a significant expense to the practice; and

WHEREAS, Physician practices are required to use certified EMR systems for participation in various government programs and with third party payors; and

WHEREAS, Government changes the requirements for participation in the various programs requiring updates in EMR software; and

WHEREAS, In many cases, EMR vendors pass on the cost of these updates to the physician practice; therefore be it

RESOLVED, That our American Medical Association advocate for policy requiring EMR vendors to absorb the cost of software updates required for compliance and participation in government and third-party programs, instead of passing on these expenses to physicians. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/09/17
Whereas, Recently introduced proposed legislation, H.R. 620: The ADA Education and Reform Act of 2017, would amend the Americans with Disabilities Act of 1990 to promote compliance through education, to clarify the requirements for demand letters, and to provide for a notice and cure period before the commencement of a private civil action; and

Whereas, H.R. 620 provides for the Disability Rights Section of the Department of Justice to develop a program to educate state and local governments and property owners on strategies for promoting access for persons with a disability; and

Whereas, The most concerning portion of this proposed legislation, the “notice and cure” period, would essentially require a person with a disability to send a letter of notification to a business or other public facility that it was out of compliance with the law, and allows a grace period before one could file suit. This provision allows for the business or other public facility to report on how the situation will be fixed within 60 days, and allows another 120 days for the business to fix or make substantial progress toward rectification; and

Whereas, This provision would remove the incentive for businesses and other public facilities to voluntarily comply with the ADA’s accessibility requirements; and

Whereas, This bill was designed to prevent non-meritorious lawsuits based on noncompliance with Title III of the ADA; however, the courts already have tools to address fraudulent or unscrupulous claims; and

Whereas, It would become the responsibility of the persons with a disability to act to address the barriers to access with the business owner, placing the heaviest burden of responsibility on individuals with disabilities, who the law was intended to protect; and

Whereas, Similar legislation has been recently introduced, such as H.R. 1493: ADA Law Suit Clarification Act of 2017, and H.R. 3571: The Reasonable ADA Compliance Act of 2017; therefore be it

RESOLVED, That our American Medical Association support legislative changes to the Americans with Disabilities Act of 1990, to educate state and local government officials and property owners on strategies for promoting access to persons with a disability (New HOD Policy); and be it further
RESOLVED, That our AMA oppose legislation amending the Americans with Disabilities Act of 1990, that would increase barriers for disabled persons attempting to file suit to challenge a violation of their civil rights. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/10/17

References
H.R. 620: The ADA Education and Reform Act of 2017

RELEVANT AMA POLICY

Threats Against Physicians Based on Americans With Disabilities Act D-90.994
Our AMA encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA's Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.
Citation: BOT Rep. 6, I-05; Reaffirmed: BOT Rep. 10, A-15

Enhancing Accommodations for People with Disabilities H-90.971
Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.
Citation: Res. 705, A-13
WHEREAS, It has been our AMA policy to support the doctor-patient relationship; and

WHEREAS, The goal of prescription benefit managers is to reduce the use of costly medications without respect to the patient’s condition or the judgment of the patient’s doctor; and

WHEREAS, The doctor who has evaluated the patient and relies on years of experience and ongoing education is the best one to judge the optimum, most cost effective approach for the patient; and

WHEREAS, Many of the most useful medications for the treatment of some grave diseases such as ulcerative colitis and Crohn’s disease require the use of advanced technology for their development and result in costly medications; and

WHEREAS, It is best to use the most effective medications in the care of seriously ill patients at an early stage of their treatment before there is irreparable harm; and

WHEREAS, Such considerations have led the Crohn’s & Colitis Foundation, the Digestive Disease National Coalition, American Academy of Dermatology, the Arthritis Foundation, Epilepsy Foundation, Lupus and Allied Diseases Association, US Pain Foundation, American Gastroenterological Association, and Digestive Disease National Coalition to advocate for this bill on Capitol Hill this year; therefore be it

RESOLVED, That our American Medical Association support HR 2077, a bill to amend the Employee Retirement Income Security Act of 1974 to require a group health plan (or health insurance coverage offered in connection with such a plan) to provide an exceptions process for any medication step therapy protocol, and for other purposes (New HOD Policy); and be it further

RESOLVED, That our AMA further support, as part of this legislation, that such a request shall be granted as quickly as the disease or condition of the participant or beneficiary requires, but no later than three days after the day of receipt of the request. For circumstances in which the applicable medication step therapy protocol may seriously jeopardize the life, health, or ability to regain maximum function of the participant or beneficiary, such a request shall be granted on an expedited basis, and no later than 24 hours after receipt of such request. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(I-17)

Introduced by: American Academy of Sleep Medicine

Subject: The Clinical Use of a Home Sleep Apnea Test

Referred to: Reference Committee B
(Ralph J. Nobo, Jr., MD, Chair)

Whereas, For the purposes of this resolution, the term “physician” refers to a medical provider who is licensed to practice medicine; and

Whereas, Obstructive sleep apnea (OSA) is a chronic medical disease that involves the collapse or near-collapse of the upper airway during sleep despite an ongoing effort to breathe; and

Whereas, OSA afflicts nearly 30 million U.S. adults\(^1\), and the prevalence of OSA has increased substantially over the last two decades and is likely to continue rising in tandem with an escalation in obesity and the aging of our population\(^2\); and

Whereas, Untreated OSA is a potentially lethal disease that has a detrimental impact on health and well-being, increasing the risk of high blood pressure, cardiovascular disease, stroke, Type 2 diabetes, depression and mortality\(^3\); and

Whereas, A home sleep apnea test (HSAT) is a medical assessment that may be used for the diagnosis of OSA in uncomplicated adults presenting with signs and symptoms that indicate an increased risk of moderate to severe OSA\(^4\); and

Whereas, Most HSAT studies, including randomized controlled trials that are most generalizable to clinical practice, have involved accredited sleep centers and the clinical expertise of board-certified sleep medicine physicians; and

Whereas, Data suggest that sleep medicine accreditation and certification are associated with higher quality care for patients with OSA\(^5\); therefore be it

RESOLVED, That it be the policy of our American Medical Association that: (1) the diagnosis of obstructive sleep apnea (OSA) or primary snoring constitutes the practice of medicine; (2) that the need for, and appropriateness of, a home sleep apnea test (HSAT) for purposes of diagnosing OSA or primary snoring or evaluating treatment efficacy must be based on the patient’s medical history and a face-to face examination by a physician, either in person or via telemedicine; and (3) that an HSAT is a medical assessment that must be ordered by a physician to diagnose OSA or evaluate treatment efficacy in the practice of medicine (New HOD Policy); and be it further

RESOLVED, That it be our AMA’s policy that (1) an HSAT should not be used for general screening of asymptomatic populations for OSA; (2) diagnosis of OSA, assessment of treatment efficacy, and treatment decisions must not be based solely on automatically scored HSAT data, which could lead to sub-optimal care that jeopardizes patient health and safety; and (3) for purposes of diagnosing OSA or evaluating treatment efficacy, the raw data from the HSAT device must be reviewed and interpreted by a physician who is either board-certified in sleep medicine or overseen by a board-certified sleep medicine physician (New HOD Policy); and be it further

RESOLVED, That our AMA support the legislative and regulatory efforts of interested state and specialty medical societies in opposing policies that would allow an HSAT to be ordered by a non-physician and distributed or used for purposes of diagnosing OSA or evaluating treatment efficacy without the oversight of a physician. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/11/17
Introduced by: American Association of Public Health Physicians  
Washington  

Subject: Treating Opioid Use Disorder in Correctional Facilities  

Referred to: Reference Committee B  
(Ralph J. Nobo, Jr., MD, Chair)  

Whereas, The opioid epidemic has become a critical threat to public health in the U.S., with  
drug overdoses now the leading cause of accidental death and opioids being responsible for 61  
percent of those deaths\(^1\); and  

Whereas, Approximately one-third of heroin users pass through correctional facilities  
annually\(^2\) and up to 60 percent of the incarcerated population has a substance use disorder\(^3\);  
and  

Whereas, Individuals recently released from prison have a high risk of overdose death,  
particularly during the first two weeks after release when their risk is 130 times greater than that  
of the non-incarcerated population\(^4\); and  

Whereas, Correctional facilities rarely treat opioid withdrawal with opioid agonist therapy, which  
is the most effective, evidence-based treatment for this condition, and rarely provide opioid  
agonist therapy even to inmate-patients who have been stabilized on it prior to entry\(^5,6\), resulting  
in unnecessary suffering and sometimes death; and  

Whereas, Effective treatment for opioid use disorder, including pharmacotherapy, improves  
medical and mental health outcomes\(^7\) and reduces spread of infectious diseases\(^8\) and, in the  
incarcerated population, reduces deaths during incarceration\(^9\), reduces deaths immediately  
following release\(^10\), and reduces recidivism\(^11\); and

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Whereas, The National Commission on Correctional Health Care in a 2016 position paper12 established that evidence-based treatment of substance use disorders, including use of opioid-agonist therapy for opioid use disorder, should be provided in correctional facilities; therefore
be it
RESOLVED, That our American Medical Association advocate for legislation, standards, policies and funding that encourage correctional facilities to increase access to evidence-based treatment of opioid use disorder, including initiation and continuation of opioid replacement therapy, in correctional facilities within the United States (New HOD Policy); and be it further
RESOLVED, That our AMA support legislation, standards, policies and funding that encourage correctional facilities within the United States to work in ongoing collaboration with addiction treatment providers, case managers, social workers, and pharmacies in the communities where patients are released to offer post-incarceration treatment plans for opioid use disorder, including education, medication for addiction treatment, and medication for preventing overdose deaths. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17

Whereas, More than 100,000 people in the United States die annually of alcohol or drug-related causes, making it the fourth leading cause of preventable death1; and

Whereas, Other mental and physical illnesses commonly co-occur with alcohol and drug use2; and

Whereas, The federal statutes authorizing the current regulations governing the confidentiality of drug and alcohol treatment and prevention records, 42 CFR Part 2, were written more than 40 years ago; and

Whereas, Major changes in the organization and financing of substance use disorder treatment have occurred since then, including integrated health systems and electronic medical records; and

Whereas, The Health Insurance Portability and Accountability Act (HIPAA), the HIPAA Privacy Rule, the Affordable Care Act (ACA), and the Health Information Technology for Economic and Clinical Health (HITECH) Act have created consistent privacy and security standards for the exchange of health information for treatment, payment, and health care operations, and established protections against disclosure of health information without patient consent; and

Whereas, 42 CFR Part 2 now creates obstacles to safe, quality care for persons with substance use disorder; and

Whereas, Persons with substance use disorder continue to face stigma and discrimination in civil society, and unauthorized disclosure of their medical records may result in adverse employment, housing, public benefit, or child custody actions; therefore be it


RESOLVED, That our American Medical Association seek regulatory and legislative changes that better balance patients’ privacy protections against the need for health professionals to be able to offer appropriate medical services to patients with substance use disorders (Directive to Take Action); and be it further

RESOLVED, That our AMA seek regulatory and legislative changes that enable physicians to fully collaborate with all clinicians involved in providing health care services to patients with substance use disorders (Directive to Take Action); and be it further

RESOLVED, That our AMA support continued protections against the unauthorized disclosure of substance use disorder treatment records outside the healthcare system. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17
Whereas, The Medicare Quality Payment Program (QPP), authorized under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), was passed in bipartisan fashion; and

Whereas, Most physicians eligible for QPP initially fall under the Merit-Based Incentive Payment System (MIPS), a competitive composite score which would adjust Medicare payments based on calculated quality; and

Whereas, MIPS bonuses or penalties under the statute initially reflected +/- 4% of the Physician Fee Schedule, increasing to +/- 9% in subsequent years; and

Whereas, The CMS 2018 QPP Proposed Rule subjects Medicare Part B drug reimbursement to MIPS\(^1\) adjustments, representing a fundamental departure both from previous CMS programs (such as the Value-Based Payment Modifier) as well as the intent of Congress; and

Whereas, Physicians largely do not control the pass-through costs associated with Part B drugs, with inclusion of drug costs unfairly amplifying the bonus or penalty in specialties which administer high-cost drugs; and

Whereas, The median financial impact for practices in some specialties under the proposal is estimated to range from approximately 16% to 29%\(^2\), well beyond the Congressionally enacted 4% penalty, cuts which would bankrupt practices receiving negative adjustments; and

Whereas, The inclusion of Part B drugs unjustly punishes or rewards specialties with high utilization of drugs critical to the treatment of their patient and exacerbates the range of payments adjustments established in law; therefore be it

RESOLVED, That our American Medical Association continue work with impacted specialties to actively lobby the federal government to exclude Medicare Part B drug reimbursement from the Merit-Based Incentive Payment System (MIPS) payment adjustment as part of the Quality Payment Program (QPP). (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17

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\(^1\) Medicare Program; CY 2018 Updates to the Quality Payment Program, 82 Federal Register 125, 30010-30500 (June 30, 2017) (to be codified at 42 CFR Part 414), 30150.

RELEVANT AMA POLICY

Preserving a Period of Stability in Implementation of the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) D-390.950
1. Our AMA will advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA) was enacted.
2. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA, which includes assurances that CMS has conducted appropriate testing, including physicians' ability to participate and validation of accuracy of scores or ratings, and has necessary resources to implement provisions regarding MIPS and APMs.
3. Our AMA will advocate that CMS provide for a stable transition period for the implementation of MACRA that includes a suitable reporting period.

Citation: Res. 242, A-16;
Whereas, Nationally, spending on prescription drugs comprise an estimated 17 percent of total health care costs;¹ and
Whereas, After accounting for discounts/rebates, drug spending is an estimated average of 10 to 15 percent higher in the United States than in Canada, France, and Germany;² and
Whereas, Patients are affected by high prescription drug costs particularly when cost-containment strategies shift more costs to patients in the form of higher co-payments/cost sharing, causing higher patient cost exposure, which can reduce patient adherence, and lead to negative health outcomes;³ and
Whereas, The Homeland Security Appropriations Act of 2007 prohibits customs and border security funding to be used to prevent a person from importing a prescription drug from Canada that would otherwise comply with FDA standards--if the medication is “on their person,” for personal-use only, and if the quantity does not exceed a 90-day supply; and
Whereas, The requirement that personally-imported prescription drugs from Canada must otherwise comply with FDA standards can trigger FDA review; and
Whereas, The FDA has issued enforcement guidelines that allow FDA staff who receive referrals of imported drug cases from customs and border personnel to use their discretion and on a case-by-case basis to allow entry of otherwise illegal FDA-regulated products when the quantity and purpose are clearly for personal use, and the product does not present an unreasonable risk to the use;⁴ and
Whereas, Although the 2003 Medicare Modernization Act authorized the development of regulations that would allow waivers for individual drug importation, no Secretary of Health and Human Services has issued such waivers; and

⁴ US Food and Drug Administration. Information on Importation of Drugs. Prepared by the Division of Import Operations and Policy, FDA (available online at https://www.fda.gov/forindustry/importprogram/ucm173751.htm)
Whereas, The current legal climate appears to offer some enforcement discretion, but the personal importation of prescription drugs from Canada remains illegal and there is no guarantee of protection for individuals who do so; and

Whereas, The Safe and Affordable Drugs from Canada Act, bipartisan legislation authored by Sen. Klobuchar (MN) and Sen. McCain (AZ), would allow individuals to import into the US a personal supply of prescription drugs from an approved Canadian pharmacy and dispensed by a licensed pharmacist; and

Whereas, Personal drug importation from Canada will not solve the problem of prescription drugs prices, but incremental efforts deserve support; and

Whereas, Current AMA Policy D-110.983 specifically addresses importation by drug wholesalers and importation via Internet sales, it does not address the issue of importation from a Canadian pharmacy for personal use only; therefore be it

RESOLVED, That our American Medical Association support legislation that would allow for the personal purchase and importation of prescription drugs obtained directly from a licensed Canadian pharmacy, provided such drugs are for personal use and of a limited quantity. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/12/17

RELEVANT AMA POLICY

Prescription Drug Importation and Patient Safety D-100.983

Our AMA will:
(1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported;
(2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured;
(3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation; and
(4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts.

Citation: BOT Rep. 3, I-04; Reaffirmation A-09; Reaffirmed in lieu of: Res. 817, I-16
WHEREAS, People with severe mobility impairments often face significant challenges to access of medical care due to problems with cognition, communication, mobility, community access, insurance, and providers’ lack of familiarity with the needs and preferences of people with disabilities; and

WHEREAS, Care provided for patients with severely impaired mobility requires greater investment of time, staff, and office equipment such as adjustable height chairs or tables, patient lift teams or electric lifts, and adjustable leg supports; and

WHEREAS, Current reimbursement structures for evaluation and management services (E/M) do not account for the increased time and investment needed to provide comprehensive patient centered care for patients with severely impaired mobility, and thus have the potential to decrease access to appropriate and timely medical care for these patients; therefore be it

RESOLVED, That our American Medical Association support additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments (New HOD Policy); and be it further

RESOLVED, That our AMA support that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law (New HOD Policy); and be if further

RESOLVED, That our AMA support that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/05/17

References:
RELEVANT AMA POLICY

Federal Legislation on Access to Community-Based Services for People with Disabilities H-290.970 - Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual's needs, and to provide equal access to community-based attendant services and supports. Citation: Res. 917, I-07; Reaffirmed: BOT Rep. 22, A-17

Medical Care of Persons with Developmental Disabilities H-90.968
1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.
3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.
9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities. Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17

Equal Access for Physically Challenged Physicians H-90.987 - Our AMA supports equal access to all hospital facilities for physically challenged physicians as part of the Americans with Disabilities Act. Citation: (Res. 816, I-91; Reaffirmed: Sunset Report, I-01; Modified: CSAPH Rep. 1, A-11

See also: Community Mobility Devices H-90.978; Access to Public Buildings for Handicapped Persons H-90.999; Enhancing Accommodations for People with Disabilities H-90.971
Whereas, The Centers for Medicare and Medicaid Services (CMS) expressed desire to revise current Evaluation and Management (E/M) documentation guidelines; and

Whereas, AMA also publishes E/M documentation guidelines in its annual CPT book; and

Whereas, The medical provider community benefits from the regulatory clarity achieved when both CMS and CPT documentation guidelines are aligned and consistent (as well as when other payer documentation requirements, such as those of Medicaid programs, are aligned) with CMS/Medicare and CPT; and

Whereas, Pediatric caregivers confront unique history, physical exam, and medical decision making challenges in documenting their patients’ care both from the perspective of progressively advancing age as well as evolving developmental stage; and

Whereas, The American Academy of Pediatrics is a fully committed participant in the CPT process and has extensive experience in representing the clinical and coding needs of the pediatric community; therefore be it

RESOLVED, That, in the process of collaborating with the Centers for Medicare and Medicaid Services for the future revision of Evaluation and Management Documentation Guidelines, our American Medical Association rely on the American Academy of Pediatrics in addressing the needs of pediatricians and their patients. (New HOD Policy)

Fiscal Note: None

Received: 10/11/17

References:
Proposed Rule, Department of Health and Human Services, Centers for Medicare and Medicaid Services, 42 CFR Parts 405, 410, 414, 424, 425, Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program (Page 374 of PDF).
Whereas, Healthy People 2020 defines “social determinants of health” as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks”\(^1\); and

Whereas, The estimated number of deaths attributable to social factors in the United States is comparable to the number attributed to pathophysiological and behavioral causes\(^2\); and

Whereas, There is strong evidence that increased investment in selected social services and models of partnership between healthcare and social services (including housing support, nutrition assistance, case management, and integrated healthcare and housing services) can confer substantial health benefits and reduce healthcare costs for targeted populations\(^3\); and

Whereas, Programs such as the Medicaid-funded Community Support Program for People Experiencing Chronic Homelessness (CSPECH), started in 2006 by the Massachusetts Behavioral Health Partnership and the Massachusetts Housing and Shelter Alliance, are associated with up to an $11,914 reduction in annual per-person healthcare costs and an annual per-person net savings of up to $7,013\(^4\); and

Whereas, A National Quality Forum panel of experts suggests that not adjusting for patients’ sociodemographic factors might actually harm patients, exacerbate disparities in care, and produce misleading performance scores for a variety of providers\(^5\); and

Whereas, Even though a shift has begun from paying for volume (fee-for-service) to paying for quality, known as value-based payment (VBP), there is concern that VBP designs that don’t account for social risk factors could harm socially at-risk populations\(^6\); and

Whereas, An ad hoc committee, requested by the Department of Health and Human Services and convened by the National Academies of Sciences, Engineering, and Medicine, found that changes to the current VBP system to account for social risk factors would especially influence the lives of patients who have historically experienced barriers to accessing high-quality

\(^{1}\) US Department of Health and Human Services, Office of Disease Prevention and Health Promotion. www.healthypeople.gov.
\(^{5}\) National Quality Forum, Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors: Technical Report, August 2014.
healthcare, and that accounting for social risk factors in quality measurement and payment in combination with complementary approaches may achieve the policy goals of reducing disparities in access, quality, and outcomes and promote health equity; therefore be it

RESOLVED, That our American Medical Association support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 10/12/17

RELEVANT AMA POLICY

Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.
Citation: CME Rep. 11, A-06; Reaffirmation A-11; Modified in lieu of Res. 908, I-14; Reaffirmed in lieu of Res. 306, A-15
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 817
(I-17)

Introduced by: New Mexico

Subject: Addressing the Site of Service Differential

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

Whereas, Health care costs continue to rise faster than the rate of inflation, and are now
approaching 20% of GDP, and the country cannot afford to continue diverting resources into
health care from other sectors of the economy such as education and infrastructure; and

Whereas, Hospitals and hospital owned outpatient clinics are paid under the Hospital Outpatient
Prospective Payment System (HOPPS), and are given an annual increase of approximately 3%
based on the government’s Market Basket estimate of the cost of providing health care, goods
and services by hospitals; and

Whereas, Practice expense has increased by inflation, but also by increased regulatory
requirements, including EHRs, data submission to attempt to measure quality, Medicare
Advantage plans imposing all the prior authorization requirements of commercial plans but
paying at Medicare rates; and

Whereas, Many practices now offer sophisticated outpatient services such as imaging, infusion,
extensive laboratory support, etc., and must purchase the same equipment and hire the same
personnel as hospitals, but are unable to charge facility fees to cover the infrastructure costs the
way hospitals can, further widening the difference in infrastructure expenses between practices
and hospitals; and

Whereas, Physician fees paid under the Physician Fee Schedule (PFS) did not increase under
the 15 years of the Sustainable Growth Rate (SGR) law, and are only increasing a fraction of a
percent under MACRA, thus creating a large and increasing Site of Service Differential between
the payment to hospitals and the payment to practices not owned by hospitals, for exactly the
same services; and

Whereas, The ongoing widening of the Site of Service Differential has made it increasingly
difficult for independent practices to compete with hospital owned practices, resulting in the
accelerated acquisition of practices by hospitals and therefore a shift from the less expensive
PFS to the much more expensive HOPPS, increasing health care costs and decreasing patient
and physician choice, without any proven increase in quality of care; and

Whereas, MedPAC in its June 2017 report\(^1\) and in previous reports to Congress, expressed
concerns "that consolidation among and between hospitals and physicians has increased prices
without any increase in quality... [and] by creating true 'site-neutral' payments, the Medicare
program could be further insulated from the cost of physician–hospital consolidation"; and

Whereas, Hospitals attempt to justify the higher HOPPS payment by claiming that they provide more charity care than independent practices, but there is no good data on the amount of charity care given by hospitals or independent practices, nor any clarity regarding the methods by which uncompensated care is estimated or compared, nor consideration of the fact that under Medicare, hospital owned practices can collect a significant percentage of billed charges for uncompensated care but independent practices cannot; and

Whereas, Practice expense has not been studied since the Practice Expense Advisory Committee completed its work over a decade ago; and

Whereas, Existing AMA Policies (H-330.925 and D-330.997) address payment disparities between hospitals and ambulatory surgery centers, but there is no existing policy concerning the global Site of Service Differential issue and no policy addressing providing equivalent facility fees and equivalent uncompensated care reimbursement to independent practices and hospital owned practices; therefore be it

RESOLVED, That our American Medical Association study the Site of Service Differential with a report back no later than the 2018 Interim Meeting, including:

a) The rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements;

b) The increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance;

c) The expense of maintaining hospital based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs;

d) The methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges (Directive to Take Action); and be it

further

RESOLVED, That our AMA advocate for a combined Health Care Payment System for patients who receive care that is paid for by the Centers for Medicare and Medicaid Services (CMS), that:

a) Follows the recommendation of MedPAC1 to pay "Site-Neutral" reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS);

b) Pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and

c) Provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17

RELEVANT AMA POLICY

Appropriate Payment Level Differences by Place and Type of Service H-330.925
Our AMA (1) encourages CMS to adopt policy and establish mechanisms to fairly reimburse physicians for office-based procedures; (2) encourages CMS to adopt a site neutral payment
policy for hospital outpatient departments and ambulatory surgical centers; (3) advocates for the use of valid and reliable data in the development of any payment methodology for the provision of ambulatory services; (4) advocates that in place of the Consumer Price Index for all Urban Consumers (CPI-U), CMS use the hospital market basket index to annually update ambulatory surgical center payment rates; (5) encourages the use of CPT codes across all sites-of-service as the only acceptable approach to payment methodology; and (6) will join other interested organizations and lobby for any needed changes in existing and proposed regulations affecting payment for ambulatory surgical centers to assure a fair rate of reimbursement for ambulatory surgery.


Appropriate Payment Level Differences by Place and Type of Service D-330.997

1. Our AMA encourages CMS to: (A) define Medicare services consistently across settings and, in particular, to avoid the use of diagnosis codes in determining Medicare payments to hospital outpatient departments and other ambulatory settings; and (B) adopt payment methodology for hospital outpatient departments and ambulatory surgical centers that will assist in leveling the playing field across all sites-of-service. If necessary, the AMA should consider seeking a legislative remedy to the payment disparities between hospital outpatient departments and ambulatory surgical centers.

2. Our AMA will continue to encourage the CMS to collect data on the frequency, type and cost of services furnished in off-campus, provider-based departments.


Offsetting the Costs of Providing Uncompensated Care H-160.923

Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

Citation: CMS Rep. 8, A-05; Reaffirmation A-07; Modified: CMS Rep. 01, A-17
Resolved, That our American Medical Association amend Policy H-130.948, “On-Call Physicians,” by addition to read as follows:

H-130.948 On-Call Physicians

Our AMA:

(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;

(2) advocates that physician on-call coverage for emergency departments be guided by the following principles:

(a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.

(b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.

(c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.
(d) Physicians should be provided adequate compensation for being available and providing on-call and emergency services.

(e) Hospital medical staff by-laws and emergency department policies regarding on-call physicians’ responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.

(f) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.

(g) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.

(h) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.

(i) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff;

(3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans’ enrollees; and

(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans’ enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA develop and make available policy guidance for physicians to negotiate with hospital medical staffs to support physician compensation for on call and emergency services. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17

RELEVANT AMA POLICY

On-Call Physicians H-130.948
Our AMA:

(1) strongly encourages physicians and hospitals to work collaboratively to develop solutions based on adequate compensation or other appropriate incentives as the preferred method of ensuring on-call coverage and will monitor and oppose any state legislative or regulatory efforts mandating emergency room on-call coverage as a requirement for medical staff privileges and state licensure that are not supported by the state medical association;

(2) advocates that physician on-call coverage for emergency departments be guided by the following principles: (a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients. (b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients. (c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.

(d) Hospital medical staff by-laws and emergency department policies regarding on-call physicians responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements. (e) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage. (f) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care. (g) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained. (h) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff; (3) supports the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans’ enrollees; and

(4) supports the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans’ enrollees or be subject to significant fines similar to the civil monetary penalties that can be imposed on hospitals and physicians for violation of EMTALA.

Citation: CMS Rep. 3, I-99; Reaffirmation A-00; Modified: Sub. Res. 217, I-00; Reaffirmation I-01; Reaffirmation A-07; Appended and Reaffirmed: CMS Rep. 1, I-09
Whereas, Some commercial insurance companies may be considering or proposing discontinuation of payment for consultation codes; and

Whereas, When providing a consultation a physician must often review substantial prior documentation; refine the differential diagnosis; recommend diagnostic and/or therapeutic options; educate the patient regarding diagnostic and other considerations, prognosis and treatment options; and coordinate next steps with the patient’s often myriad other providers; and

Whereas, Failing to acknowledge the difference in work between a consultation and the relative simplicity of assuming the care of a patient with a known diagnosis is misguided and will predictably limit the ability of providers to consult on complex cases; and

Whereas, Discontinuation of payment for consultation codes could result in another barrier to patient care by dissuading usual coordination of care, as the additional work that goes into providing a consultation and coordinating care amongst other treating physicians would not be properly recognized; and

Whereas, When the Centers for Medicare and Medicaid Services discontinued payment for consultation codes in 2010, the medical community raised significant concerns because in its decision the agency failed to recognize the expertise and additional collaboration that is reflected in the use of consultation codes; and

Whereas, Commercial insurance entities should provide alternative provider outreach and education on coding errors rather than eliminate important codes such as consultation codes; therefore be it

RESOLVED, That our American Medical Association proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change (Directive to Take Action); and be it further
RESOLVED, Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, that our AMA request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17

RELEVANT AMA POLICY

Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953
1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services? (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17
Whereas, The Medicare Date of Service (DOS) policy for Clinical and Laboratory Pathology Specimens was adopted by the Centers for Medicare & Medicaid Services (CMS) in 2007, creating the Laboratory 14-Day Rule\(^1\); and

Whereas, The 14-Day Rule specifies that billing for “complex diagnostic laboratory services” performed on pathologic specimens collected in the hospital setting be bundled into the inpatient diagnosis-related group (DRG) or outpatient (OPPS) payments made to the hospital if ordered within 14 days of discharge\(^2\); and

Whereas, Payment bundling of pathologic tests, including molecular and genomic testing of cancer specimens, creates a strong disincentive to hospitals to perform or send out specialized pathologic tests during the 14-day window after discharge, leading to delays in diagnosis and therapy\(^3\); and

Whereas, Since the adoption of the 14-day rule in 2007 there have been a growing number of therapies that are targeted to specific somatic (tumoral) mutations and delays in molecular testing can result in delays in initiation of these effective treatments; and

Whereas, Amidst complaints from stakeholders, CMS is currently considering changes to the Medicare Outpatient Prospective Payment System (OPPS) including whether to limit or eliminate the 14-Day Rule\(^4,5\); therefore be it

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\(^1\) 42 CFR § 414.510
\(^3\) “Affordable Care Act (Pub. L. 111-148), Section 3113(a)(2) defines the term "complex diagnostic laboratory test" to mean a diagnostic laboratory test—(A) that is an analysis of gene protein expression, topographic genotyping, or a cancer chemotherapy sensitivity assay; (B) that is determined by the Secretary to be a laboratory test for which there is not an alternative test having equivalent performance characteristics; (C) which is billed using a Healthcare Common Procedure Coding System (HCPCS) code other than a not otherwise classified (NOC) code under such Coding System; (D) which is approved or cleared by the Food and Drug Administration or is covered under title XVIII of the Social Security Act; and (E) is described in section 1861(s)(3) of the Social Security Act (42 U.S.C. 1395x(s)(3))."
\(^5\) Centers for Medicare & Medicaid Services. Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs. 82 Federal Register 138, 33558-33724. 20 Jul 2017. 33650-33653.
RESOLVED, That our American Medical Association actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17

RELEVANT AMA POLICY

Laboratory Services Contracted by a Physician H-260.998
Our AMA believes that: (1) laboratories should bill and collect from patients or third party payers for laboratory services; (2) attending physicians are entitled to fair compensation for professional services rendered; and (3) bills for laboratory services performed by attending physicians should show the location where services were rendered and a description of such services.

Whereas, The majority of women of reproductive age in the United States currently use at least one contraceptive method, with more than 99 percent having used contraception during their lifetime; and

Whereas, Health care practitioners frequently prescribe hormonal contraception to treat a variety of conditions; and

Whereas, Fifty-eight percent of pill users cite non-contraceptive health benefits such as treatment for excessive menstrual bleeding, menstrual pain, and acne as reasons for using the method. Hormonal contraceptives are also used to treat conditions such as Polycystic Ovary Syndrome (PCOS) and endometriosis; and

Whereas, Hormonal contraception can also reduce a woman’s risk of developing ovarian and endometrial cancer; and

Whereas, Hormonal contraception provides a myriad of benefits beyond the expected reproductive planning by decreasing the number of unintended pregnancies and pregnancy-related health risks such as preeclampsia, gestational diabetes, and complications of childbirth; and

Whereas, Unintended pregnancies cost American taxpayers at least $21 billion each year. Nationally, 68 percent of these unintended pregnancies were paid for by public insurance programs including Medicaid, Children’s Health Insurance Program, and the Indian Health Service; and
Whereas, For every public dollar invested in contraception, short-term Medicaid expenditures are reduced by $7.09 for the pregnancy, delivery, and early childhood care related to births from unintended pregnancies; and

Whereas, Expanding access to free contraception has a positive impact on insurance costs. Estimates show that the cost to provide contraception per year ranges from $100-$600 while the cost for prenatal care, delivery, and newborn care averages $18,000-$28,000 under private insurance; and

Whereas, 77 percent of women and 64 percent of men support increased access to no-cost hormonal contraception; and

Whereas, The category of employers who can claim a moral objection to providing contraception to their employees at no-cost was broadened through the October 6, 2017 Rule, thereby taking away this preventive health benefit from a significant number of women; therefore be it

RESOLVED, That our American Medical Association advocate to rescind the 2017 Rule “Moral Exemptions and Accommodations for Coverage of Certain Preventive Services under the Affordable Care Act,” to ensure that all women have access to no-cost hormonal contraception. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17

RELEVANT AMA POLICY

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Citation: Sub. Res. 224, I-15

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Whereas, Pregnancy-related deaths doubled in the United States in the past 25 years;¹ and
Whereas, An estimated 700 women die of pregnancy-related causes each year in the US and another 65,000 have serious health complications; many of these deaths and complications can be prevented²; and
Whereas, Leading causes of maternal deaths include cardiovascular disease, cardiomyopathy, thromboembolism, obstetric hemorrhage, preeclampsia, sepsis, hypertension and obesity, and more recently, drug overdose and maternal suicide;³ and
Whereas, The US lags far behind all other industrialized countries and is the only high-resource country with a rising maternal mortality rate;⁴ and
Whereas, There are significant and widening disparities in maternal mortality and morbidity, disproportionately impacting black women in the US;⁵ and
Whereas, There is a need to redouble efforts to prevent maternal deaths and national initiatives are underway to mobilize clinical and public health resources to improve safety in obstetric care, including establishing and strengthening state Maternal Mortality Review Committees; and
Whereas, The Centers for Disease Control and Prevention and ACOG recommend that all states have an active Maternal Mortality Review Committee; and
Whereas, Maternal Mortality Review Committees conduct systematic, confidential analysis of the medical and non-medical circumstances of deaths that occur during pregnancy or up to one year after--for the purpose of taking action to reduce the risk of women dying from complications of pregnancy; and
Whereas, Maternal Mortality Review Committees make specific, data-driven recommendations, identifying gaps in services and systems to prevent future deaths and near-misses as well as strengths in the systems of care that should be supported or expanded; and

Whereas, Review Committees conduct their confidential interviews and analysis of birth and
death certificates, autopsy, hospital ER, medical transport, social services, and mental health
records and reports within a culture of promoting safety—not to assign blame; and

Whereas, Maternal health and mortality are important indicators of the quality of health care and
are at the core of what it means to have healthy, vibrant communities; therefore be it

RESOLVED, That our American Medical Association support the important work of maternal
mortality review committees (New HOD Policy); and be it further

RESOLVED, That our AMA support work with state and specialty medical societies to advocate
for state and federal legislation establishing Maternal Mortality Review Committees (New HOD
Policy); and be it further

RESOLVED, That our AMA support work with state and specialty medical societies to secure
funding from state and federal governments that fully supports the start-up and ongoing work of
state Maternal Mortality Review Committees. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/05/17
Whereas, Smoking is the leading preventable cause of death, killing an estimated 480,000 persons in the United States and costing an estimated $325 billion in medical expenses and lost productivity each year; and

Whereas, If current trends continue, an estimated 5.6 million children in the United States alive today will ultimately die prematurely from smoking; and

Whereas, On August 17, 2006, a U.S. federal district court issued a 1,682 page final ruling in the case of United States v. Philip Morris concluding that Philip Morris, Altria, R.J. Reynolds, and other tobacco companies were in violation of the United States Racketeer Influenced and Corrupt Organizations (RICO) Act, noting that their goal has been “to make money with little, if any, regard for individual illness and suffering, soaring health costs, or the integrity of the legal system”; and

Whereas, To successfully prosecute defendants for a violation of the RICO Act, it must be proved that they have an ongoing pattern of criminal activity and the court found that “the evidence in this case clearly establishes that Defendants have not ceased engaging in unlawful activity...” and that “…their continuing conduct misleads consumers in order to maximize Defendants revenues by recruiting new smokers (the majority of whom are under the age of 18), preventing current smokers from quitting, and thereby sustaining the industry”; and

Whereas, The tobacco companies were ordered to publish “corrective statements” regarding “(a) the adverse health effects of smoking; (b) the addictiveness of smoking and nicotine; (c) the lack of any significant health benefit from smoking ‘low tar,’ ‘light,’ ‘ultralight,’ ‘mild,’ and ‘natural,’ cigarettes; (d) defendants’ manipulation of cigarette design and composition to ensure optimum nicotine delivery; and (e) the adverse health effects of exposure to secondhand smoke”; and

Whereas, On May 22, 2009, a three-judge panel of the U.S. Court of Appeals issued a unanimous opinion affirming many of the findings of the lower court and all 4,088 findings of fact outlined in the ruling; and

Whereas, On June 28, 2010, the U.S. Supreme Court refused to hear appeals in the RICO verdict against the tobacco companies, thereby allowing the racketeering verdict to stand; and

Whereas, On April 25, 2017, a three-judge panel of the U.S. Court of Appeals unanimously ordered that the tobacco companies publish corrective statements; and
Whereas, The corrective statements will finally be published, beginning in November, in major newspapers, advertised during primetime on such national television channels as NBC, CBS, ABC or other channels with comparable reach; printed on “onserts” affixed to cigarette packages, and placed on the tobacco companies’ websites; and

Whereas, In all 50 U.S. states, one or more of the tobacco companies found to be in violation of RICO have retained lobbyists to influence state lawmakers; and

Whereas, Public support is strong for lawmakers to reject potential tobacco industry influences, particularly meals, gifts, or campaign contributions from tobacco companies or their lobbyists; and

Whereas, A strong majority of Americans think lawmakers shouldn’t trust tobacco companies as much as they trust other companies and, further, that lawmakers shouldn’t trust tobacco company lobbyists to provide accurate information on tobacco issues; and

Whereas, When asked if a tobacco-related law was written or influenced by a tobacco company or a tobacco company lobbyist, very few Americans think lawmakers should “leave the law as it is” and a strong majority of Americans think lawmakers should either “revise the law” or “remove the law and start over”; and

Whereas, Internal tobacco industry documents reveal that that tobacco companies have written or heavily influenced tobacco-related public policies since at least 1967; and

Whereas, Interference by the tobacco industry in government policy-making is known to be an important reason for governments’ failure to adopt proven measures to reduce tobacco consumption; and

Whereas, There is strong public support for a wide range of public policies actively opposed by tobacco companies yet proven effective in reducing the harms of tobacco by preventing initiation of smoking among youth and/or encouraging cessation of smoking among current users; therefore be it

RESOLVED, That our American Medical Association collaborate with members, component societies, and other interested public health organizations such as the Campaign for Tobacco Free Kids, Truth Initiative, the American Cancer Society, the American Lung Association and the American Heart Association, to help educate the public and policymakers about the tobacco companies’ organized conspiracy to commit fraud leading to the federal court verdict finding them in violation of the Racketeer Influenced and Corrupt Organization Act (RICO) and resulting in the corrective statements as ordered by the U.S. Court of Appeals in United States vs. Philip Morris (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage our component societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly influenced by tobacco companies or their lobbyists and encourage lawmakers to remediate all such influences, to reject any potential tobacco industry influences in the future, and to formally censure the tobacco companies for their fraudulent and harmful behavior. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/08/17
Whereas, Consistent increases in the life expectancy of the population of a country are expected and considered an indication of effective public health systems and health care and socio-economic well-being; and

Whereas, Life expectancy for the U.S. population decreased by 0.1 year from 2014 (78.9 years) to 2015 (78.8 years), including a decrease of 0.2 years (76.5 years to 76.3 years) for males and a decrease of 0.1 years (81.3 years to 81.2 years) for females; and

Whereas, U.S. life expectancy is now lower than in most high-income countries and this gap is projected to increase, and

Whereas, Continuous decline in the age-adjusted death rate for the total population of a country is expected and considered a sign of public health progress, good health care, and socio-economic well-being; and

Whereas, From 2014 to 2015, the age-adjusted death rate for the total population rose significantly for the first time since 1999, increasing by 1.2%, with age-adjusted death rate increases for non-Hispanic white males, non-Hispanic white females, and non-Hispanic black males; and

Whereas, Between 1999 and 2014, premature mortality increased in white individuals and in American Indians and Alaska Natives, and given that the magnitude of annual mortality increases in the USA is extremely unusual in high-income countries, a rapid public health response is needed to avert further premature deaths; therefore be it

RESOLVED, That our American Medical Association raise awareness of the recent reversals in the improvement of overall death rates and life expectancy with the message that these new problems in the United States are different from all other developed countries and that these trends need to be reversed promptly (Directive to Take Action); and be it further

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1 CDC National Center for Health Statistics, Mortality in the United States, 2015.NCHS Data Brief No. 267, December 2016


RESOLVED, That our AMA call on the legislative and executive branches of the Federal
Government to fund and carry out investigations into the causes of these very unusual
decreases in life expectancy and increases in death rates in order to design multi-disciplinary
interventions to reverse these troubling changes (Directive to Take Action); and be it further
RESOLVED, That our AMA encourage state and local medical societies to raise awareness of
the new problems of decreasing life expectancy and increasing population death rates as
indicators of major public health problems and advocate for local investigation of the causes and
remedies for these disturbing problems. (New HOD Policy)

Fiscal Note: Modest - between $1,000 - $5,000.

Received: 10/12/17
WHEREAS, A number of medical conditions have been associated with exposures to environmental chemicals in utero or during early development; and

WHEREAS, Differentiating likely causal connections from coincidental associations or confounders is complex and prone to misrepresentation; and

WHEREAS, Budgetary concerns threaten current and ongoing pediatric toxicological education and consultation services; and

WHEREAS, Socioeconomically disadvantaged and other susceptible populations are more likely to bear the health burden of many chemical exposures; therefore be it

RESOLVED, That our American Medical Association support the mission of and ongoing funding of academically-based regional Pediatric Environmental Health Specialty Units (PEHSU) by the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention (ATSDR/CDC) and the Environmental Protection Agency (EPA) (New HOD Policy); and be it further

RESOLVED, That our AMA support educational and consultative activities of the PEHSU program with local pediatricians, medical toxicologists, obstetricians, and others providing care to pregnant patients (New HOD Policy); and be it further

RESOLVED, That our AMA encourage the continuing training of physicians specializing in pediatric environmental health. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
Whereas, Four healthy lifestyle factors--never smoking, maintaining a healthy weight, exercising regularly, and following a healthy diet--together appear to be associated with as much as an 80 percent reduction in the risk of developing the most common and deadly chronic diseases, such as cardiovascular disease, cancer, and diabetes; and

Whereas, The Bipartisan Policy Center has called for improving medical education and training in “topics such as nutrition and physical activity that have an important role to play in the prevention and treatment of obesity and chronic diseases,” since “these topics have traditionally received little attention in formal medical school curricula”; and

Whereas, Many physicians and other healthcare providers are not adequately trained in nutrition and physical activity and other lifestyle components in a way that could mitigate disease development and progression; and

Whereas, In a report from 2010, only 25% of medical schools surveyed required a dedicated nutrition course (down from 30% in 2004) and only 27% of schools surveyed met the minimum 25 required hours of nutrition instruction set by the National Academy of Sciences (down from 38% in 2004); and

Whereas, Patients advised to quit smoking by their physicians are 1.6 times more likely to quit than patients not receiving physician advice; however, most smokers do not receive this advice when visiting their physicians; and

Whereas, Just 34% of U.S. adults reported exercise counseling at their last medical visit; and

Whereas, In a study of internal medicine physicians, less than half reported confidence in knowledge of local exercise facilities, American College of Sports Medicine (ACSM) guidelines, and behavior modification techniques; therefore be it

RESOLVED, That our American Medical Association support legislation that incentivizes and/or provides funding for the inclusion of lifestyle medicine education in medical school education, graduate medical education, and continuing medical education, including but not limited to education in nutrition, physical activity, behavior change, sleep health, tobacco cessation, alcohol use reduction, emotional wellness, and stress reduction. (New HOD Policy)
Fiscal Note: Minimal - less than $1,000.

Received: 10/12/17

RELEVANT AMA POLICY

Healthy Lifestyles H-425.972
Our AMA: (1) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (2) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (3) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management.

Citation: Res. 423, A-12

E-8.11 Health Promotion and Preventive Care

Medicine and public health share an ethical foundation stemming from the essential and direct role that health plays in human flourishing. While a physicians role tends to focus on diagnosing and treating illness once it occurs, physicians also have a professional commitment to prevent disease and promote health and well-being for their patients and the community.

The clinical encounter provides an opportunity for the physician to engage the patient in the process of health promotion. Effective elements of this process may include educating and motivating patients regarding healthy lifestyle, helping patients by assessing their needs, preferences, and readiness for change and recommending appropriate preventive care measures. Implementing effective health promotion practices is consistent with physicians duties to patients and also with their responsibilities as stewards of health care resources.

While primary care physicians are typically the patients main source for health promotion and disease prevention, specialists can play an important role, particularly when the specialist has a close or long-standing relationship with the patient or when recommended action is particularly relevant for the condition that the specialist is treating. Additionally, while all physicians must balance a commitment to individual patients with the health of the public, physicians who work solely or primarily in a public health capacity should uphold accepted standards of medical professionalism by implementing policies that appropriately balance individual liberties with the social goals of public health policies.

Health promotion should be a collaborative, patient-centered process that promotes trust and recognizes patients self-directed roles and responsibilities in maintaining health. In keeping with their professional commitment to the health of patients and the public, physicians should:

(a) Keep current with preventive care guidelines that apply to their patients and ensure that the interventions they recommend are well supported by the best available evidence.

(b) Educate patients about relevant modifiable risk factors.

(c) Recommend and encourage patients to have appropriate vaccinations and screenings.

(d) Encourage an open dialogue regarding circumstances that may make it difficult to manage chronic conditions or maintain a healthy lifestyle, such as transportation, work and home environments, and social support systems.

(e) Collaborate with the patient to develop recommendations that are most likely to be effective.

(f) When appropriate, delegate health promotion activities to other professionals or other resources available in the community who can help counsel and educate patients.

(g) Consider the health of the community when treating their own patients and identify and notify public health authorities if and when they notice patterns in patient health that may indicate a health risk for others.

(h) Recognize that modeling health behaviors can help patients make changes in their own lives.

Collectively, physicians should:

(i) Promote training in health promotion and disease prevention during medical school, residency and in continuing medical education.

(j) Advocate for healthier schools, workplaces and communities.

(k) Create or promote healthier work and training environments for physicians.

(l) Advocate for community resources designed to promote health and provide access to preventive services.

(m) Support research to improve the evidence for disease prevention and health promotion.