MEMORANDUM FROM THE SPEAKER OF THE HOUSE OF DELEGATES

- All Delegates, Alternate Delegates and others receiving this material are reminded that it refers only to items to be considered by the House.

- No action has been taken on anything herein contained, and it is informational only.

- Only those items that have been acted on finally by the House can be considered official.

- The Interim Meeting is focused on advocacy issues. A resolution committee (see AMA Bylaw 2.13.3) considers each resolution and recommends that the item be considered or not considered at the Interim Meeting. Items that meet the following definition of advocacy or that are considered urgent are recommended for acceptance:

  Active use of communication and influence with public and private sector entities responsible for making decisions that directly affect physician practice, payment for physician services, funding and regulation of education and research, and access to and delivery of medical care.

Resolutions pertaining to ethics should also be included in the agenda. Remaining items are recommended against consideration, but any delegate may request consideration when resolutions are presented for consideration (during Sunday’s “Second Opening” Session). A simple majority of those present and voting is required for consideration.

- REMINDER: Only the Resolve portions of the resolutions are considered by the House of Delegates. The Whereas portions or preambles are informational and explanatory only.
UNDERSTANDING THE RECORDING OF AMERICAN MEDICAL ASSOCIATION POLICY

Current American Medical Association (AMA) policy is catalogued in PolicyFinder, an electronic database that is updated after each AMA House of Delegates (HOD) meeting and available online. Each policy is assigned to a topical or subject category. Those category headings are alphabetical, starting with “abortion” and running to “women”; the former topic was assigned the number 5, and “women” was assigned 525. Within a category, policies are assigned a 3 digit number, descending from 999, meaning that older policies will generally have higher numbers within a category (eg, 35.999 was initially adopted before 35.984). A policy number is not affected when it is modified, however, so a higher number may have been altered more recently than a lower number. Numbers are deleted and not reused when policies are rescinded.

AMA policy is further categorized into one of four types, indicated by a prefix:

- “H” – for statements that one would consider positional or philosophical on an issue
- “D” – for statements that direct some specific activity or action. There can be considerable overlap between H and D statements, with the assignment made on the basis of the core nature of the statement.
- “G” – for statements related to AMA governance
- “E” – for ethical opinions, which are the recommendations put forward in reports prepared by the Council on Ethical and Judicial Affairs and adopted by the AMA-HOD

AMA policy can be accessed at ama-assn.org/go/policyfinder.

The actions of the AMA-HOD in developing policy are recorded in the Proceedings, which are available online as well. Annotations at the end of each policy statement trace its development, from initial adoption through any changes. If based on a report, the annotation includes the following abbreviations:

- BOT – Board of Trustees
- CME – Council on Medical Education
- CCB – Council on Constitution and Bylaws
- CMS – Council on Medical Service
- CEJA – Council on Ethical and Judicial Affairs
- CSAPH – Council on Science and Public Health
- CLRPD – Council on Long Range Planning and Development

If a resolution was involved, “Res” is indicated. The number of the report or resolution and meeting (A for Annual; I for Interim) and year (two digits) are also included (eg, BOT Rep. 1, A-14 or Res. 319, I-12).

AMA policy is recorded in the following categories, and any particular policy is recorded in only a single category.

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<th>Category</th>
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<td>640.000 Governance: Advocacy and Political Action</td>
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LIST OF MATERIAL INCLUDED IN THIS HANDBOOK (I-17)

Resolutions and reports have been collated by referral according to reference committee assignment. In the listing below, referral is indicated by letter in parenthesis following the title of the report. Resolutions have been numbered according to referrals (i.e., those referred to the Reference Committee on Amendments to Constitution and Bylaws begin with 1, Reference Committee B begins with 201, etc.).

The informational reports contain no recommendations and will be filed on Sunday, November 12, unless a request is received for referral and consideration by a Reference Committee (similar to the use of a consent calendar).

1. Memorandum from the Speaker

2. Understanding the Recording of American Medical Association Policy

3. Declaration of Professional Responsibility - Medicine's Social Contract with Humanity

4. Delegate / Alternate Delegate Job Description, Roles and Responsibilities

5. Seating Allocation and Seating Chart for the House of Delegates

6. Hotel Maps

7. Official Call to the Officers and Members of the AMA
   - Listing of Delegates and Alternate Delegates
   - Officials of the Association and AMA Councils
   - House of Delegates Reference Committee Members

8. Note on Order of Business

9. Summary of Fiscal Notes

FOLLOWING COLLATED BY REFERRAL

10. Report(s) of the Board of Trustees - Gerald E. Harmon, MD, Chair
    01 Redefining AMA's Position on ACA and Healthcare Reform (Info. Report)
    02 2017 AMA Advocacy Efforts (Info. Report)
    03 Removing Restrictions on Federal Funding for Firearms Violence Research (Info. Report)
    04 Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care (Info. Report)
    05 Effective Peer Review (Amendments to C&B)
    06 Electronically Prescribed Controlled Substances Without Added Processes (B)
    07 Medical Reporting for Safety-Sensitive Positions (Amendments to C&B)
    08 2018 Strategic Plan (Info. Report)
    09 Parental Leave (Info. Report)
    10 High Cost to Authors for Open Source Peer Reviewed Publications (F)

11. Report(s) of the Council on Ethical and Judicial Affairs - Dennis S. Agliano, MD, Chair
    02 Ethical Physician Conduct in the Media (Amendments to C&B)
03 Supporting Autonomy for Patients with Differences of Sex Development (DSD) (Amendments to C&B)

12. Opinion(s) of the Council on Ethical and Judicial Affairs - Dennis S. Agliano, MD, Chair
   01 Amendment to E-2.3.2, "Professionalism in Social Media" (Info. Report)

13. Report(s) of the Council on Medical Education - Lynne M. Kirk, MD, Chair
   02 A National Continuing Medical Education Repository (Info. Report)

14. Report(s) of the Council on Medical Service - Paul A. Wertsch, MD, Chair
   03 Non-Physician Screening Tests (J)
   05 Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding (J)

15. Report(s) of the Council on Science and Public Health - Robert A. Gilchick, MD, Chair
   01 Universal Color Scheme for Respiratory Inhalers (K)
   02 Targeted Education to Increase Organ Donation (K)
   03 Neuropathic Pain as a Disease (K)
   04 National Drug Shortages Update (K)

16. Report(s) of the Speakers - Susan R. Bailey, MD, Speaker; Bruce A. Scott, MD, Vice Speaker
   01 Recommendations for Policy Reconciliation (Info. Report)

17. Resolutions
   001 Disaggregation of Data Concerning the Status of Asian-Americans (Amendments to C&B)
   002 Intimate Partner Violence Policy and Immigration (Amendments to C&B)
   003 Revision of AMA Policy Regarding Sex Workers (Amendments to C&B)
   004 Tissue Handling (Amendments to C&B)
   201 Improving FDA Expedited Approval Pathways (B)
   202 Sexual Assault Survivors’ Rights (B)
   203 Bidirectional Communication for EHR Software and Pharmacies (B)
   204 EHR Vendors Responsible for Health Information Technology (B)
   205 Health Plan, Pharmacy, Electronic Health Records Integration (B)
   206 Defending Federal Child Nutrition Programs (B)
   207 Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs (B)
   208 Increased Use of Body-Worn Cameras by Law Enforcement Officers (B)
   209 Government Mandated Sequester (B)
   210 Merit-Based Incentive Payment System and Small Practices (B)
   211 Exclusive State Control of Methadone Clinics (B)
   213 Barriers to Price Transparency (B)
   214 APRN Compact (B)
   215 Relieve Burden for Living Organ Donors (B)
   216 Relationship with US Department of Health and Human Services (B)
   217 Regulations Regarding Medical Tool and Instrument Repair (B)
   601 Physician Burnout and Wellness Challenges (F)
   801 Chronic Care Management Payment for Patients Also on Home Health (J)
   802 Opposition to Medicaid Work Requirements (J)
   803 Air Ambulance Regulations and Reimbursements (J)
   804 Prior Authorization (J)
   805 A Dual System for Universal Health Care in the United States (J)
806 Mandate Transparency by Pharmacy Benefit Managers (J)
807 Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals (J)
808 Opposition to Reduced Payment for the 25 Modifier (J)
809 Expansion of Network Adequacy Policy (J)
810 Pharmacy Benefit Managers and Prescription Drug Affordability (J)
811 Update OBRA Nursing Facility Preadmission Screening Requirements (J)
812 Medicare Coverage of Services Provided by Proctored Medical Students (J)
813 Sustain Patient-Centered Medical Home Practices (J)
901 Harmful Effects of Screen Time in Children (K)
902 Expanding Expedited Partner Therapy to Treat Trichomoniasis (K)
903 Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (K)
904 Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients (K)
905 Addressing Social Media Usage and its Negative Impacts on Mental Health (K)
906 Opioid Abuse in Breastfeeding Mothers (K)
907 Addressing Healthcare Needs of Foster Children (K)
908 Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability (K)
909 Expanding Naloxone Programs (K)
910 Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination (K)
952 Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training (K)
953 Fees for Taking Maintenance of Certification Examination (K)
954 Developing Physician Led Public Health / Population Health Capacity in Rural Communities (K)
955 Minimization of Bias in the Electronic Residency Application Service Residency Application (K)
956 House Physicians Category (K)
957 Standardization of Family Planning Training Opportunities in OB-BYN Residencies (K)
958 Sex and Gender Based Medicine in Clinical Education (K)

18. Resolutions not for consideration
   212 Physician Identification (Not for consideration)
   602 Creation of LGBTQ Health Specialty Section Council (Not for consideration)
   603 A Guide for Best Health Practices for Seniors Living in Retirement Communities (Not for consideration)
   951 Financial Protections for Doctors in Training (Not for consideration)
DECLARATION OF PROFESSIONAL RESPONSIBILITY:  
MEDICINE’S SOCIAL CONTRACT WITH HUMANITY

Preamble

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

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

Declaration

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

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

We make these promises solemnly, freely, and upon our personal and professional honor.

Adopted by the House of Delegates of the American Medical Association in San Francisco, California on December 4, 2001
Delegate/Alternate Delegate Job Description, Roles and Responsibilities

At the 1999 Interim Meeting, the House of Delegates adopted as amended Recommendation 16 of the final report of the Special Advisory Committee to the Speaker of the House of Delegates. This recommendation included a job description and roles and responsibilities for delegates and alternate delegates. The description and roles and responsibilities were modified at the 2002 Annual Meeting by Recommendation 3 of the Joint Report of the Board of Trustees and Council on Long Range Planning and Development. The modified job description, qualifications, and responsibilities are listed below.

Delegates and Alternate Delegates should meet the following job description and roles and responsibilities:

Job Description and Roles and Responsibilities of AMA Delegates/Alternate Delegates

Members of the AMA House of Delegates serve as an important communications, policy, and membership link between the AMA and grassroots physicians. The delegate/alternate delegate is a key source of information on activities, programs, and policies of the AMA. The delegate/alternate delegate is also a direct contact for the individual member to communicate with and contribute to the formulation of AMA policy positions, the identification of situations that might be addressed through policy implementation efforts, and the implementation of AMA policies. Delegates and alternate delegates to the AMA are expected to foster a positive and useful two-way relationship between grassroots physicians and the AMA leadership. To fulfill these roles, AMA delegates and alternate delegates are expected to make themselves readily accessible to individual members by providing the AMA with their addresses, telephone numbers, and e-mail addresses so that the AMA can make the information accessible to individual members through the AMA web site and through other communication mechanisms. The qualifications and responsibilities of this role are as follows:

A. Qualifications
   - AMA member.
   - Elected or selected by the principal governing body or the membership of the sponsoring organization.
   - The AMA encourages that at least one member of each delegation be involved in the governance of their sponsoring organization.

B. Responsibilities
   - Regularly communicate AMA policy, information, activities, and programs to constituents so he/she will be recognized as the representative of the AMA.
   - Relate constituent views and suggestions, particularly those related to implementation of AMA policy positions, to the appropriate AMA leadership, governing body, or executive staff.
   - Advocate constituent views within the House of Delegates or other governance unit, including the executive staff.
   - Attend and report highlights of House of Delegates meetings to constituents, for example, at hospital medical staff, county, state, and specialty society meetings.
   - Serve as an advocate for patients to improve the health of the public and the health care system.
   - Cultivate promising leaders for all levels of organized medicine and help them gain leadership positions.
   - Actively recruit new AMA members and help retain current members.
   - Participate in the AMA Membership Outreach Program.
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REFERENCE COMMITTEE HEARING LOCATIONS

SUNDAY, NOVEMBER 12
8:30 am-Noon

Ref Cmte Amendments to C&B 312
Reference Committee B 313C
Reference Committee F Kalakaua Ballroom
Reference Committee J 313A
Reference Committee K 311
Official Call to the Officers and Members of the American Medical Association to attend the Interim Meeting of the House of Delegates in Honolulu, Hawaii, November 11-14, 2017.

The House of Delegates will convene at 2 p.m. on November 11, at the Hawaii Convention Center.

**STATE ASSOCIATION REPRESENTATION IN THE HOUSE OF DELEGATES**

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**SPECIALTY SOCIETY REPRESENTATION IN THE HOUSE OF DELEGATES**

- American Academy of Dermatology: 4
- American Academy of Family Physicians: 16
- American Academy of Neurology: 3
- American Academy of Ophthalmology: 4
- American Academy of Orthopaedic Surgeons: 5
- American Academy of Otolaryngology - Head and Neck Surgery: 3
- American Academy of Pediatrics: 8
- American Academy of Physical Med. & Rehabilitation: 2
- American College of Cardiology: 4
- American College of Emergency Physicians: 6
- American College of Gastroenterology: 2

Remaining eligible national medical specialty societies (96) are entitled to one delegate each.

The Academic Physicians Section, Integrated Physician Practice Section, International Medical Graduates Section, Medical Student Section, Minority Affairs Section, Organized Medical Staff Section, Resident and Fellow Section, Senior Physicians Section, Women Physicians Section, Young Physicians Section, Army, Navy, Air Force, Public Health Service, Department of Veterans Affairs, Professional Interest Medical Associations, AMWA, AOA and NMA are entitled to one delegate each.

<table>
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<tr>
<th>Category</th>
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<td>State Medical Associations</td>
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<td><strong>Total Delegates</strong></td>
<td><strong>556</strong></td>
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Registration facilities will be maintained at the Hawaii Convention Center.

David O. Barbe, MD, MHA  
President

Susan R. Bailey, MD  
Speaker, House of Delegates

Jesse M. Ehrenfeld, MD, MPH  
Secretary
2017-2018
OFFICIALS OF THE ASSOCIATION
BOARD OF TRUSTEES (OFFICERS)

President - David O. Barbe ................................................................. Mountain Grove, Missouri
President-Elect - Barbara L. McAneny ......................................................... Albuquerque, New Mexico
Immediate Past President - Andrew W. Gurman ........................................ Hollidaysburg, Pennsylvania
Secretary - Jesse M. Ehrenfeld ..................................................................... Nashville, Tennessee
Speaker, House of Delegates - Susan R. Bailey ............................................ Fort Worth, Texas
Vice Speaker, House of Delegates - Bruce A. Scott ..................................... Louisville, Kentucky

Willarda V. Edwards (2020) ......................................................................... Baltimore, Maryland
Gerald E. Harmon, Chair (2021) ................................................................. Pawleys Island, South Carolina
Patrice A. Harris (2019) ................................................................................ Atlanta, Georgia
Russell W.H. Kridel (2018) ............................................................................ Houston, Texas
William A. McDade (2020) ........................................................................ Metaire, Louisiana
S. Bobby Mukkamala (2021) ......................................................................... Flint, Michigan
Stephen R. Pernut (2018) ............................................................................. Lewes, Delaware
Jack Resneck, Jr, Chair-Elect (2018) ............................................................. San Rafael, California
Ryan J. Ribeira (2019) .................................................................................. Mountain View, California
Karthik V. Sarma (2018) .............................................................................. Los Angeles, California
Carl A. Sirio (2018) ..................................................................................... Pittsburgh, Pennsylvania
Georga A. Tuttle (2019) ............................................................................... Lebanon, New Hampshire
Kevin W. Williams (2020) ........................................................................... Nashville, Tennessee

COUNCILS OF THE AMA

COUNCIL ON CONSTITUTION AND BYLAWS
Colette R. Willins, Chair, Westlake, Ohio (2019); Jerome C. Cohen, Vice Chair, Loch Sheldrake, New York (2021);
Naiim S. Ali, Burlington, Vermont (Resident) (2018); Patricia L. Austin, Alamo, California (2018); Madelyn E. Butler,
Tampa, Florida (2018); Pino D. Colone, Howell, Michigan (2020); Cyndi J. Yag-Howard, Naples, Florida (2018); Joy Lee,
Washington, District of Columbia (Student) (2018); Ex Officio, without vote: Susan R. Bailey, Fort Worth, Texas; Bruce
A. Scott, MD, Louisville, Kentucky.
Secretary: Janice Robertson, Chicago, Illinois.

COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS
Dennis S. Agliano, Tampa, Florida Chair (2018); David Fleming, Columbia, Missouri (2024); Marc Mendelsohn,
Brooklyn, New York (Resident) (2018); Kathryn L. Moseley, Ann Arbor, Michigan (2020); Alexander M. Rosenau,
Allentown, Pennsylvania (2022); James E. Sabin, Boston, Massachusetts (2019); Laurie Schleimer, Cambridge,
Massachusetts (Student) (2019); Peter A. Schwartz, Reading, Pennsylvania (2023); Monique A. Spillman, Dallas, Texas
(2021).
Secretary: Elliott Crigger, Chicago, Illinois.

COUNCIL ON LEGISLATION
E. Scott Ferguson, West Memphis, Arkansas, Chair (2018); Jerry D. Kennett, Columbia, Missouri, Vice Chair (2018);
David H. Aizuss, Encino, California (2018); Seyed H. Aleali, Bridgeport, Connecticut (2018); Hans C. Arora, Cleveland
Heights, Ohio (Resident) (2018); Mary S. Carpenter, Winner, South Dakota (2018); Christopher C. Clifford, Reno, Nevada
(Student) (2018); Gary W. Floyd, Keller, Texas (2018); Linda B. Ford, Bellevue, Nebraska (AMPAC Observer) (2018);
Marilyn J. Heine, Dresher, Pennsylvania (2018); Beth Irish, Bend, Oregon (Alliance Liaison) (2018); Heather A. Smith,
New York, New York (2018); David T. Tayloe, Jr., Goldsboro, North Carolina (2018); Willie Underwood, III, Buffalo,
Secretary: George Cox, Washington, District of Columbia.
COUNCIL ON LONG RANGE PLANNING AND DEVELOPMENT
Glenn A. Loomis, LaGrangeville, New York, Chair (2019); Alfred Herzog, Hartford, Connecticut, Vice Chair (2019); Mary T. Herald, Summit, New Jersey (2018); James Goodyear, North Wales, Pennsylvania (2021); Shannon Pryor, Washington, District of Columbia (2020); Clarence Chou, Milwaukee, Wisconsin (2020); Edmond Cabbabe, St. Louis, Missouri (2021); Gary Thal, Northbrook, Illinois (2021); Matthew Lecuyer, Providence, Rhode Island (Resident) (2019); Katherine Marsh (Student) (2018).
Secretary: Susan Close, Chicago, Illinois.

COUNCIL ON MEDICAL EDUCATION
Lynne M. Kirk, Dallas, Texas, Chair (2019); Carol D. Berkowitz, Torrance, California, Chair-elect (2019); Patricia L. Turner, Chicago, Illinois, Immediate Past Chair (2019); Jacqueline A. Bello, Bronx, New York, Member-at-large (2021); Robert B. Goldberg, New York, New York (2021); Arjun Gupta, East Hanover, New Jersey (Student) (2018); Cynthia A. Jumper, Lubbock, Texas (2020); Liana Pucas, Durham, North Carolina (2021); Niranjan V. Rao, New Brunswick, New Jersey (2018); Luke V. Selby, Denver, Colorado (Resident) (2020); Krystal L. Tomei, Cleveland, Ohio (2021); John P. Williams, Pittsburgh, Pennsylvania (2019).
Secretary: Carrie Radabaugh, Chicago, Illinois.

COUNCIL ON MEDICAL SERVICE
Paul A. Wertsch, Madison, Wisconsin, Chair (2018); James G. Hinsdale, San Jose, California, Chair-elect (2019); Meena Davuluri, New York, New York (Resident) (2020); Lisa Egbert, Dayton, Ohio (2021); W. Alan Harmon, Jacksonville, Florida (2020); Lynn Jeffers, Camarillo, California (2020); Peter Lavine, Washington, District of Columbia (2018); Asa Lockhart, Tyler, Texas (2018); Peter S. Lund, Erie, Pennsylvania (2018); Thomas Madejski, Medina, New York (2019); Sarah Smith, Anaheim, California (Student) (2018); Lynda M. Young, Worcester, Massachusetts (2021).
Secretary: Val Carpenter, Chicago, Illinois.

COUNCIL ON SCIENCE AND PUBLIC HEALTH
Robert A. Gilchick, Los Angeles, California, Chair (2018); Robyn F. Chatman, Cincinnati, Ohio, Chair-elect (2019); John T. Carlo, Dallas, Texas (2021); Noel N. Deep, Antigo, Wisconsin (2019); Alexander Ding, Belmont, California (2020); Kira A. Geraci-Ciardullo, Mamaroneck, New York (2018); Christina Kratschmer, Brooklyn, New York (Student) (2018); Mary LaPlante, Cleveland, Ohio (2021); Michael Lubrano, San Francisco, CA (Resident) (2020); Michael M. Miller, Madison, Wisconsin (2018); Bruce M. Smoller, Chevy Chase, Maryland (2019); David J. Welsh, Batesville, Indiana (2020).
Secretary: Barry Dickinson, Chicago, Illinois.

AMERICAN MEDICAL ASSOCIATION POLITICAL ACTION COMMITTEE
Vidya S. Kora, Michigan City, Indiana, Chair; Lyle S. Thorstenson, Nacogdoches, Texas, Secretary; Grayson W. Armstrong, Boston, Massachusetts (Resident); Brooke M. Buckley, Annapolis, Maryland; Steven J. Fleischman, New Haven, Connecticut; Linda B. Ford, Bellevue, Nebraska; Benjamin Z. Galper, McLean, Virginia; Dev A. Gnanadev, Colton, California; Stephen A. Imbue, Florence, South Carolina; Ashtin Jeney, Washington, District of Columbia (Student); James L. Milam, Libertyville, Illinois; Michael Suk, Danville, Pennsylvania.
Executive Director and Treasurer: Kevin Walker, Washington, District of Columbia.
EX OFFICIO MEMBERS OF THE HOUSE OF DELEGATES

The Former Presidents and Former Trustees of the Association, the Chairs of the Councils of the AMA and the current General Officers, with the exception of the Speaker and Vice Speaker of the House of Delegates, are ex officio, nonvoting members of the House of Delegates.

FORMER PRESIDENTS

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<tr>
<th>Name</th>
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<tr>
<td>Lonnie R. Bristow</td>
<td>1995-1996</td>
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<td>2011-2012</td>
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<td>Yank D. Coble, Jr.</td>
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<td>Richard F. Corlin</td>
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<td>Nancy W. Dickey</td>
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<td>Ardis D. Hoven</td>
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FORMER TRUSTEES

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</table>
SPECIALTY AND SERVICE SOCIETY REPRESENTATIVES

(The following are not members of the House of Delegates, but are representatives of the following societies which are represented in the SSS.)

American Academy of Emergency Medicine................................................................. Joseph Wood, MD, JD
American Society of Nuclear Cardiology................................................................. David Winchester, MD
Society of Gynecologic Oncologists........................................................................... Carol Brown, MD
National Lipid Association............................................................................................ Michael Davidson, MD
Society of Cardiovascular Computed Tomography............................................ Dustin Thomas, MD
Korean American Medical Association ................................................................. John Yun, MD
Association of Professors of Dermatology............................................................... Christopher R. Shea, MD
American Society for Reconstructive Microsurgery........................................... Gregory R. D. Evans, MD
American Rhinological Society................................................................................... Joseph B. Jacobs, MD
North American Neuromodulation Society............................................................. Haroon Hameed, MD
North American Neuro-Ophthalmology Society..................................................... Thomas Mizen, MD
American Association of Endocrine Surgeons........................................................ Steven De Jong, MD
American College of Medical Toxicology............................................................... Charles McKay, MD
Association of Academic Physiatrists...................................................................... Samuel Chu, MD
American Association of Hip and Knee Surgeons................................................. Edward Tanner, MD
American Society of Neuroimaging........................................................................... Vernon Rowe, MD
MEMBERS OF THE HOUSE OF DELEGATES - NOVEMBER 2017
The following is a list of delegates and alternate delegates to the House of Delegates as reported to the Executive Vice President

**Medical Association of the State of Alabama**

**Delegate(s)**
- Jorge Alsip, Daphne AL
- Steven P Furr, Jackson AL
- Beverly F Jordan, Enterprise AL
- George C Smith, Lineville AL

**Alternate Delegate(s)**
- Raymond Broughton, Theodore AL
- B Jerry Harrison, Haleyville AL
- Mark H LeQuire, Montgomery AL
- William Schneider, Huntsville AL

**Regional Medical Student Delegate(s)**
- Ben Bush, Mobile AL

**Alaska State Medical Association**

**Delegate(s)**
- Alex Malter, Juneau AK

**Alternate Delegate(s)**
- Mary Ann Foland, Anchorage AK

**Arizona Medical Association**

**Delegate(s)**
- Daniel P Aspery, Phoenix AZ
- Veronica K Dowling, Show Low AZ
- Gary R Figge, Tucson AZ
- Thomas H Hicks, Tucson AZ
- M Zuhdi Jasser, Phoenix AZ

**Alternate Delegate(s)**
- Timothy Fagan, Tucson AZ
- Ross Goldberg, Phoenix AZ
- Michael Hamant, Tucson AZ
- Marc Leib, Phoenix AZ
- Katherine Marsh, Tucson AZ

**Regional Medical Student Delegate(s)**
- Daniel Hintze, Tucson AZ

**Arkansas Medical Society**

**Delegate(s)**
- Omar Atiq, Little Rock AR
- Amy Cahill, Pine Bluff AR
- Chad Rodgers, Little Rock AR

**Alternate Delegate(s)**
- David H Aizuss, Encino CA
- Mark Ard, Redlands CA
- Patricia L Austin, Alamo CA
- Edward Bentley, Santa Barbara CA
- J Brennan Cassidy, Newport Beach CA
- Thomas E Daglish, Visalia CA
- Kyle P Edmonds, San Diego CA
- Sidney Gold, Granada Hills CA
- James T Hay, Del Mar CA
- Robert Hertzka, Rancho Santa Fe CA
- James G Hinsdale, San Jose CA
- Vito Imbasciani, Los Angeles CA
- Steven E Larson, Riverside CA
- Arthur N Lurvey, Los Angeles CA
- Robert J Margolin, San Francisco CA
- Theodore Mazer, San Diego CA
- Helene Nepomuceno, Costa Mesa CA
- Albert Ray, San Diego CA
- Michael J Sexton, Novato CA
- Tatiana W Spirtos, Redwood City CA
- James J Strebig, Irvine CA
- Richard E Thorp, Paradise CA

**California Medical Association**

**Delegate(s)**
- Barbara J Arnold, Sacramento CA
- Dirk Stephen Baumann, Burlingame CA
- Jeffrey Brackett, Ventura CA
- Peter N Bretan, Novato CA
- Lawrence Cheung, San Francisco CA
- Luther Cobb, Eureka CA
- Pooja Desai, Riverside CA
- Alexander Ding, Belmont CA
- Suparna Dutta, Oakland CA
- Gordon Fung, San Francisco CA
- Dev A GnanaDev, Colton CA

This list does not reflect temporary changes for this meeting.
California Medical Association

Alternate Delegate(s)
- Poyin Huang, Los Angeles CA
- Alexandra Iacob, Loma Linda CA
- Scott Richard Karlan, West Hollywood CA
- Nikan Khatibi, Laguna Niguel CA
- Mark H Kogan, San Pablo CA
- Ramin Manshadi, Stockton CA
- Lisa S Miller, San Diego CA
- Richard Pan, Sacramento CA
- Sion Roy, Santa Monica CA
- Holly Yang, San Diego CA
- Marcy Zwelling, Los Alamitos CA

Resident and Fellow Sectional Delegate(s)
- Elizabeth Griffiths, San Francisco CA

Resident and Fellow Sectional Alternate Delegate(s)
- Ariel Anderson, San Diego CA

Regional Medical Student Delegate(s)
- Rachel Ekaireb, San Francisco CA
- Anna Yap, Loma Linda CA

Regional Medical Student Alternate Delegate(s)
- Trevor Cline, Sacramento CA
- Abhinaya Narayanan, Los Angeles CA
- Ali Tafreshi, Anaheim CA
- Sophia Yang, Orange CA

Colorado Medical Society

Delegate(s)
- Katie Lozano, Centennial CO
- Alethia Morgan, Denver CO
- M Ray Painter, Thornton CO
- Lynn Parry, Littleton CO
- Brigitta J Robinson, Centennial CO

Alternate Delegate(s)
- David Downs, Denver CO
- Jan Kief, Highlands Ranch CO
- Tamaan Osborne-Roberts, Denver CO
- Robert Yakely, Denver CO

Resident and Fellow Sectional Delegate(s)
- Luke Selby, Denver CO

Connecticut State Medical Society

Delegate(s)
- Michael L Carius, Stratford CT
- Michael M Deren, New London CT
- Alfred Herzog, Hartford CT
- Theodore Zanker, Cheshire CT

Alternate Delegate(s)
- Gary J Price, Guilford CT
- Bollepalli Subbarao, Middletown CT
- Donald D Timmerman, Glastonbury CT

Regional Medical Student Alternate Delegate(s)
- Devin Bageac, Farmington CT
- Imran Ghare, New Haven CT

Medical Society of Delaware

Delegate(s)
- Kelly S Eschbach, Wilmington DE

Alternate Delegate(s)
- Janice Tildon-Burton, Wilmington DE

Resident and Fellow Sectional Delegate(s)
- Stephanie Howe Guarino, Wilmington DE

Medical Society of the District of Columbia

Delegate(s)
- Joseph E Gutierrez, McLean VA
- Peter E Lavine, Washington DC

Alternate Delegate(s)
- J Desiree Pineda, Washington DC
- Raymond K Tu, Washington DC

Resident and Fellow Sectional Delegate(s)
- Jordan Warchol, Arlington VA

Florida Medical Association

Delegate(s)
- David Becker, Safety Harbor FL
- Madelyn E Butler, Tampa FL
- Ronald Frederic Giffler, Fort Lauderdale FL
- Walter Alan Harmon, Jacksonville FL
- Corey L Howard, Naples FL
- E Coy Irvin, Pensacola FL
- John Montgomery, Fleming Island FL
- Douglas Murphy, Ocala FL
- Ralph Jacinto Nobo, Bartow FL
- Arthur E Palamara, Hollywood FL

This list does not reflect temporary changes for this meeting.
Florida Medical Association

Delegate(s)
  Michael L Patete, Venice FL
  Alan B Pillersdorf, Lake Worth FL
  Aaron Sudbury, Bradenton FL
  David Winchester, Gainesville FL

Alternate Delegate(s)
  Jose F Arrascue, Atlantis FL
  Ankush Bansal, West Palm Beach FL
  James Booker, Winter Haven FL
  Andrew Cooke, Orlando FL
  Aaron Elkin, Miami FL
  James Nathan Goldenberg, Atlantis FL
  Rebecca Lynn Johnson, Tampa FL
  Trachella Johnson Foy, Jacksonville FL
  Mark E Panna, Gainesville FL
  Jason J Pirozzolo, Winter Garden FL
  Sergio B Seoane, Bartol FL
  James St Geroge, Ponte Verdra FL
  Michael Zimmer, St Petersburg FL

Resident and Fellow Sectional Alternate Delegate(s)
  Michelle Falcone, Miami FL

Regional Medical Student Delegate(s)
  Jessica Walsh O'Sullivan, Orlando FL

Regional Medical Student Alternate Delegate(s)
  Anna Beth West, Gainesville FL

Medical Association of Georgia

Delegate(s)
  S William Clark, Waycross GA
  Michael E Greene, Macon GA
  Billie Luke Jackson, Macon GA
  Joy A Maxey, Atlanta GA
  Sandra B Reed, Atlanta GA

Alternate Delegate(s)
  John S Antalis, Dalton GA
  Jack Chapman, Gainesville GA
  John Goldman, Atlanta GA
  Gary Richter, Atlanta GA
  Steven M Walsh, Roswell GA

Guam Medical Society

Delegate(s)
  Insaf Ally, Tamuning GU

Hawaii Medical Association

Delegate(s)
  Jone Geimer-Flanders, Honolulu HI
  Roger Kimura, Honolulu HI

Alternate Delegate(s)
  Christopher Flanders, Honolulu HI

Idaho Medical Association

Delegate(s)
  A Patrice Burgess, Boise ID

Alternate Delegate(s)
  Keith Davis, Shoshone ID

Illinois State Medical Society

Delegate(s)
  Thomas M Anderson, Chicago IL
  Craig Alvin Backs, Springfield IL
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  Nestor Ramirez-Lopez, Champaign IL
  Shastri Swaminathan, Chicago IL

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  Howard Axe, Arlington Heights IL
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  Katherine Tynus, Chicago IL
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Resident and Fellow Sectional Delegate(s)
  Vanessa A Stan, Chicago IL

Resident and Fellow Sectional Alternate Delegate(s)
  Amar Kelkar, Peoria IL

This list does not reflect temporary changes for this meeting.
Illinois State Medical Society

Regional Medical Student Alternate Delegate(s)
Ajeet Singh, Forest Park IL

Indiana State Medical Association

Delegate(s)
Michael Hoover, Evansville IN
Vidya S Kora, Michigan City IN
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David Welsh, Batesville IN

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Brent Mohr, South Bend IN
Fred Ridge, Linton IN
Thomas Vidic, Elkhart IN

Regional Medical Student Delegate(s)
Joshua Scantland, Indianapolis IN

Iowa Medical Society

Delegate(s)
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Kentucky Medical Association

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David J Bensema, Lexington KY
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Shawn C Jones, Jr, Louisville KY
William B Monnig, Crestview Hills KY
Robert A Zaring, Louisville KY

Louisiana State Medical Society

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Dolleen Mary Licciardi, Jefferson LA
Lee Stevens, Shreveport LA
Ezekiel Wetzel, Metairie LA

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William Clark, Baton Rouge LA
Myo Myint, New Orleans LA
Rachel Spann, New Orleans LA

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Regional Medical Student Alternate Delegate(s)
Neal Dixit, New Orleans LA

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Regional Medical Student Alternate Delegate(s)
Kimberly Dao, Brunswick ME

MedChi: The Maryland State Medical Society

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Brooke M Buckley, Annapolis MD
Loralie Dawn Ma, Fulton MD
Gary Pushkin, Baltimore MD
Padmini Ranasinghe, Baltimore MD
Megan Srinivas, Baltimore MD

This list does not reflect temporary changes for this meeting.
This list does not reflect temporary changes for this meeting.
Missouri State Medical Association
Delegate(s)
William H Huffaker, Chesterfield MO
Warren Lovinger, Nevada MO
Alternate Delegate(s)
Elie Azrak, Saint Louis MO
Joseph A Corrado, Mexico MO
Michael L O'Dell, Kansas City MO
Shannon Tai, Lisle IL
Charles W Van Way, Fairway KS

Regional Medical Student Delegate(s)
Ariel Carpenter, Columbia MO

Regional Medical Student Alternate Delegate(s)
Jared Lammert, Columbia MO

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Nicole C Clark, Helena MT

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Alternate Delegate(s)
Robert Rhodes, Lincoln NE

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Florence Jameson, Las Vegas NV
Alternate Delegate(s)
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Peter R Fenwick, Reno NV

New Hampshire Medical Society
Delegate(s)
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David Swee, Piscataway NJ
Alternate Delegate(s)
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A. Ralph Kristeller, East Hanover NJ
Soumen Samaddar, Pennington NJ
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Regional Medical Student Alternate Delegate(s)
Ilesha Sevak, Newark NJ

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Alternate Delegate(s)
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William G Liakos, Roswell NM

Medical Society of the State of New York
Delegate(s)
Abhimanyu Amamani, Brooklyn NY
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Frank G Dowling, Islandia NY
Kira Geraci-Ciardullo, Harrison NY
Daniel J Koretz, Ontario NY
William R Latreille, Malone NY
Thomas J Madejski, Medina NY
Parag Mehta, Brooklyn NY
Gregory L Pinto, Saratoga Springs NY
Charles Rothberg, Patchogue NY

This list does not reflect temporary changes for this meeting.
Medical Society of the State of New York

Delegate(s)
Joseph Sellers, Cobleskill NY
Corliss Varnum, Oswego NY
Daniel M Young, Windsor NY

Alternate Delegate(s)
Mark Adams, Fairport NY
Howard Huang, Watertown NY
John A Ostuni, Freeport NY
Barry Rabin, Syracuse NY
Abdul Rehman, Staten Island NY

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Erin Duffy, Centereach NY
Moudi Hubeishy, Buffalo NY
Pratistha Koirala, Bronx NY

North Carolina Medical Society

Delegate(s)
Timothy M Beittel, Fayetteville NC
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Mary Ann Contogiannis, Greensboro NC
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Liana Puscas, Durham NC
Charles F Willson, Greenville NC

Regional Medical Student Delegate(s)
Lauren Edgar, Winston-Salem NC

Regional Medical Student Alternate Delegate(s)
Lauren Benning, Littington NC

North Dakota Medical Association

Delegate(s)
Shari L Orser, Bismarck ND

Alternate Delegate(s)
A Michael Booth, Bismarck ND

Ohio State Medical Association

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Lisa B. Egbert, Kettering OH
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Gary R Katz, Dublin OH
William C. Sternfeld, Toledo OH
Donna A Woodson, Toledo OH

Alternate Delegate(s)
Brett Coldiron, Cincinnati OH
Shawn Cuevas, Columbus OH
Deepak Kumar, Dayton OH
Alisha Reiss, Columbus OH
Kara Richardson, Dublin OH
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Regional Medical Student Delegate(s)
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Kevin Qin, Toledo OH

Regional Medical Student Alternate Delegate(s)
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Samantha King, Columbus OH
Theodore Rader, IV, Toledo OH

Oklahoma State Medical Association

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Bruce Storms, Chickasha OK

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Jenny Boyer, Tulsa OK
Julie Hager, Oklahoma City OK
Woody Jenkins, Stillwater OK

Resident and Fellow Sectional Alternate Delegate(s)
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Regional Medical Student Delegate(s)
Helga Skaftason, Tulsa OK

Regional Medical Student Alternate Delegate(s)
Chelsea McKenzie, Tulsa OK

This list does not reflect temporary changes for this meeting.
Oregon Medical Association
Delegate(s)
  Robert Dannenhoffer, Roseburg OR
  Sylvia Ann Emory, Eugene OR
Alternate Delegate(s)
  Peter A Bernardo, Salem OR
  Carla Mc Kelvey, Bandon OR

Pennsylvania Medical Society
Delegate(s)
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  Anthony M Padula, Philadelphia PA
  Ralph Schmeltz, Pittsburgh PA
  Scott E Shapiro, Lower Gwynedd PA
  John W Spurlock, Bethlehem PA
  Martin D Trichtinger, Hatboro PA
  John P Williams, Gibsonia PA
Alternate Delegate(s)
  Erick Bergquist, Latrobe PA
  Michael A DellaVecchia, Berwyn PA
  Mark Friedlander, Naboth PA
  John P Gallagher, Sharon PA
  Kevin Owen Garrett, Allison Park PA
  Aaron E George, Chambersburg PA
  Bruce A Mac Leod, Pittsburgh PA
  Jill M Owens, Bradford PA
  Evan Pollack, Bryn Mawr PA
  Erik Saka, Philadelphia PA
  John S Trickett Jr, Scranton PA
  John Michael Vasudevan, Philadelphia PA
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  Raghuveer Puttagunta, Danville PA
Resident and Fellow Sectional Alternate Delegate(s)
  Tani Malhotra, York PA
Regional Medical Student Delegate(s)
  Neel Nabar, Philadelphia PA

Puerto Rico Medical Association
Delegate(s)
  Gonzalo V Gonzalez-Liboy, Carolina PR
  Rafael Rodriguez-Mercado, San Juan PR
Alternate Delegate(s)
  Rafael Fernandez Feliberti, Guaynabo PR
  Jose Luis Romany Rodriguez, San Juan PR

Rhode Island Medical Society
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  Alyn L Adrain, Providence RI
  Peter A Hollmann, Cranston RI
Alternate Delegate(s)
  Bradley Collins, Providence RI
  Sarah Fessler, Riverside RI

South Carolina Medical Association
Delegate(s)
  Gary A Delaney, Orangeburg SC
  H Timberlake Pearce, Beaufort SC
  Bruce A Snyder, Greenville SC
  Greg Tarasidis, Greenwood SC
Alternate Delegate(s)
  Stephen Imbeau, Florence SC
  Richard Osman, Myrtle Beach SC
  Stefanie M Putnam, Mauldin SC
  Todd Schlesinger, Charleston SC
Regional Medical Student Delegate(s)
  Ian Brastauskas, Columbia SC
Regional Medical Student Alternate Delegate(s)
  Lawrence (Taylor) Lucas, Greenville SC

South Dakota State Medical Association
Delegate(s)
  Mary Carpenter, Winner SD
Alternate Delegate(s)
  Robert L Allison, Pierre SD
Regional Medical Student Delegate(s)
  Daniel Pfefifle, Sioux Falls SD

This list does not reflect temporary changes for this meeting.
Tennessee Medical Association
Delegate(s)
Richard J DePersio, Knoxville TN
Donald B Franklin, Signal Mountain TN
John J Ingram, Alcoa TN
Lee R Morisy, Memphis TN
BW Ruffner, Signal Mountain TN
Alternate Delegate(s)
O. Lee Berkenstock, Memphis TN
Wiley T Robinson, Memphis TN
Nita Shumaker, Hixson TN
Christopher E Young, Signal Mtn TN
Regional Medical Student Alternate Delegate(s)
Anderson Webb, Smithville TN

Texas Medical Association
Delegate(s)
Susan Rudd Bailey, Fort Worth TX
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Brad G Butler, Abilene TX
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Robert T Gunby, Dallas TX
David N Henkes, San Antonio TX
Asa C Lockhart, Tyler TX
Kenneth L Mattox, Houston TX
Kevin H McKinney, Galveston TX
Clifford K. Moy, Frisco TX
Larry E Reaves, Fort Worth TX
Leslie H Secrest, Dallas TX
Lyle S Thorstenson, Nacogdoches TX
E Linda Villarreal, Edinburg TX
Alternate Delegate(s)
Gerald Ray Callas, Beaumont TX
John T Carlo, Dallas TX
Robert H Emmick, Austin TX
John G Flores, Little Elm TX
Gregory M Fuller, Keller TX
William S Gilmer, Houston TX
Alison Haddock, Houston TX
Steven R Hays, Dallas TX

This list does not reflect temporary changes for this meeting.
Medical Society of Virginia

Delegate(s)
  Lawrence K Monahan, Roanoke VA
  William Reha, Woodridge VA

Alternate Delegate(s)
  Clifford L Deal, Henrico VA
  Bhushan H Pandya, Danville VA
  Sterling N Ransone, Deltaville VA

Regional Medical Student Delegate(s)
  Thamolwan (Wan) Surakiatchanukul, Philad

Regional Medical Student Alternate Delegate(s)
  Carl Rudebusch, Richmond VA

Washington State Medical Association

Delegate(s)
  Erin Harnish, Longview WA
  L Elizabeth Peterson, Spokane WA
  Sheila D Rege, Pasco WA
  Rodney Trytko, Spokane WA

Alternate Delegate(s)
  Peter J Dunbar, Mercer Island WA
  Matthew Grierson, Bothell WA
  Nariman Heshmati, Mukliteo WA
  Shane Macaulay, Bellevue WA

West Virginia State Medical Association

Delegate(s)
  Constantino Y Amores, Charleston WV
  Joseph Barry Selby, Morgantown WV

Alternate Delegate(s)
  Hoyt Burdick, Huntington WV
  James D Felsen, Great Cacapon WV

Resident and Fellow Sectional Alternate Delegate(s)
  Daniel O'Brien, Morgantown WV

Wisconsin Medical Society

Delegate(s)
  Timothy G Mc Avoy, Waukesha WI
  Michael M Miller, Oconomowoc WI
  Charles J. Rainey, River Hills WI
  Paul A Wertsch, Madison WI
  Tosha Wetterneck, Madison WI

Alternate Delegate(s)
  Jacob Behrens, Fitchburg WI
  Nameeta Dookeran, Pewaukee WI
  Barbara Hummel, Milwaukee WI
  George Melvin Lange, Milwaukee WI
  Keshni Ramnanan, Summit WI

Resident and Fellow Sectional Delegate(s)
  Laurel Bessey, Madison WI

Regional Medical Student Delegate(s)
  Michael Rigby, Madison WI

Wyoming Medical Society

Delegate(s)
  Stephen Brown, Casper WY

Alternate Delegate(s)
  Joseph McGinley, Casper WY

This list does not reflect temporary changes for this meeting.
<table>
<thead>
<tr>
<th>Organization</th>
<th>Delegate(s)</th>
<th>Alternate Delegate(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy of Physicians in Clinical Research</td>
<td>Peter Howard Rheinstein, Severna Park MD</td>
<td>Hugh H Tilson, Chapel Hill NC</td>
</tr>
<tr>
<td>Aerospace Medical Association</td>
<td>Hernando J Ortega, San Antonio TX</td>
<td>Daniel Shoor, San Antonio TX</td>
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<tr>
<td>Air Force</td>
<td>Paul Friedrichs, Saint Louis MO</td>
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<tr>
<td>AMDA-The Society for Post-Acute and Long-Term</td>
<td>Eric Tangalos, Rochester MN</td>
<td>Rajeev Kumar, Oak Brook IL</td>
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<td>Term Care Medicine</td>
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<tr>
<td>American Academy of Allergy, Asthma &amp; Immunology</td>
<td>Steven G Tolber, Corrales NM</td>
<td>George Green, Abington PA</td>
</tr>
<tr>
<td>American Academy of Child and Adolescent Psychiatry</td>
<td>Louis Kraus, Chicago IL</td>
<td>David Fassler, Burlington VT</td>
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<tr>
<td>American Academy of Cosmetic Surgery</td>
<td>Anthony J Geroulis, Northfield IL</td>
<td>Robert F Jackson, Noblesville IN</td>
</tr>
<tr>
<td>American Academy of Dermatology</td>
<td>Hillery Johnson-Jahangir, Iowa City IA</td>
<td>Andrew P Lazar, Washington DC</td>
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<tr>
<td>American Academy of Dermatology</td>
<td>Marta Jane Van Beek, Iowa City IA</td>
<td>Cyndi J Yag-Howard, Naples FL</td>
</tr>
<tr>
<td>American Academy of Facial Plastic and Reconstructive Surgery</td>
<td>Lindsey Ackerman, Paradise Valley AZ</td>
<td>Seemal Desai, Frisco TX</td>
</tr>
<tr>
<td>American Academy of Family Physicians</td>
<td>Jerry P Abraham, Los Angeles CA</td>
<td>John Cullen, Valdez AK</td>
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<tr>
<td></td>
<td>Joanna T Bisgrove, Fitchburg WI</td>
<td>Elana Curry, Columbus OH</td>
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<td></td>
<td>John Heinemann, Canton SD</td>
<td>Daniel Loomis, Hopewell Junction NY</td>
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<tr>
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<td>Kaci Rae Larsen, Columbia MO</td>
<td>John Meigs, Brent AL</td>
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<td></td>
<td>Glenn Larsen, Columbia MO</td>
<td>Michael L Munger, Overland Park KS</td>
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<td>Anita Ravi, New York NY</td>
<td>Stephen Richards, Spirit Lakes IA</td>
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<tr>
<td></td>
<td>Julie K Wood, Leawood KS</td>
<td>Lawrence Rues, Kansas City MO</td>
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<tr>
<td></td>
<td>J. Mack Worthington, Chattanooga TN</td>
<td>Hugh Taylor, Hamilton MA</td>
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<tr>
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<td>Colette R Willins, Westlake OH</td>
<td>Janet West, Pensacola FL</td>
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<td>Gerry Curr, Columbus OH</td>
<td>Colette R Willins, Westlake OH</td>
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<td>Michael Hanak, Chicago IL</td>
<td>Lawrence Rues, Kansas City MO</td>
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<td>Douglas E Henley, Leawood KS</td>
<td>Julie K Wood, Leawood KS</td>
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<td></td>
<td>Evelyn Lynnette Lewis, Newman GA</td>
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<tr>
<td></td>
<td>Resident and Fellow Sectional Alternate Delegate(s)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Samuel Mathis, Galveston TX</td>
<td></td>
</tr>
</tbody>
</table>

*This list does not reflect temporary changes for this meeting.*
American Academy of Hospice and Palliative Medicine
Delegate(s)
Chad D Kollas, Orlando FL
Alternate Delegate(s)
Ronald J Crossno, Rockdale TX

American Academy of Insurance Medicine
Delegate(s)
Deborah Y Smart, Gurnee IL

American Academy of Neurology
Delegate(s)
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Ann Murray, Morgantown WV

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Alexandra Elizabeth Page, LaJolla CA
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Kimberly Jo Templeton, Leawood KS
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American Academy of Otolaryngology-Head and Neck Surgery
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Douglas R Myers, Vancouver WA
Robert Puchalski, Lugoff SC
Alternate Delegate(s)
James C Dennen, Ill, Alexandria VA

American Academy of Pain Medicine
Delegate(s)
Robert Wailes, Rancho Santa Fe CA
Alternate Delegate(s)
Donna Bloodworth, Alvin TX

American Academy of Pediatrics
Delegate(s)
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Carol Berkowitz, Rancho Palos Verdes CA
Melissa J Garretson, Fort Worth TX
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Ajanta Patel, Chicago IL
Samantha Rosman, Jamaica Plain MA
David T Tayloe, Goldsboro NC
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Karen Remley, Richmond VA

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Delegate(s)
Stuart Glassman, Concord NH
Susan L Hubbell, Lima OH
Alternate Delegate(s)
Mohammad Agha, Columbia MO
Brittany Bickelhaupt, San Antonio TX

American Academy of Psychiatry and the Law
Delegate(s)
Barr Wall, Providence RI
Alternate Delegate(s)
Linda Gruenberg, Chicago IL

American Academy of Sleep Medicine
Delegate(s)
Alejandro Chediak, Miami FL
Alternate Delegate(s)
Patrick J Strollo, Pittsburgh PA

This list does not reflect temporary changes for this meeting.
American Association for Geriatric Psychiatry
Delegate(s)
Allan Anderson, Easton MD

American Association for Hand Surgery
Delegate(s)
Peter C Amadio, Rochester MN
Alternate Delegate(s)
Nicholas B Vedder, Seattle WA

American Association for Thoracic Surgery
Delegate(s)
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American Association of Clinical Endocrinologists
Delegate(s)
M. Kathleen Figaro, Billendorf IA

American Association of Clinical Urologists
Delegate(s)
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American Association of Gynecologic Laparoscopists
Delegate(s)
Joseph M Maurice, Chicago IL

American Association of Neurological Surgeons
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Alternate Delegate(s)
Maya A Babu, Miami FL

American Association of Neuromuscular & Electromyography Society
Delegate(s)
William Pease, Columbus OH
Alternate Delegate(s)
Enrica Arnaudo, Newark DE

American Association of Physicians of Indian Origin
Delegate(s)
VijayaLakshmi Appareddy, Chattanooga TN

American Association of Physicians of Indian Origin
Alternate Delegate(s)
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American Association of Plastic Surgeons
Delegate(s)
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Alternate Delegate(s)
Michele Manahan, Baltimore MD

American Association of Public Health Physicians
Delegate(s)
Dave Cundiff, Olympia WA
Alternate Delegate(s)
Arlene Seid, Grantham PA

American Clinical Neurophysiology Society
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Alternate Delegate(s)
Jaime Lopez, Stanford CA

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Delegate(s)
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Alternate Delegate(s)
John M Seyerle, Cincinnati OH

American College of Cardiology
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Suma Thomas, Cleveland OH
L Samuel Wann, Whitefish Bay WI
Kim Allan Williams, Chicago IL
Alternate Delegate(s)
M Eugene Sherman, Englewood CO

American College of Chest Physicians (CHEST)
Delegate(s)
D Robert McCaffree, Oklahoma City OK

Resident and Fellow Sectional Delegate(s)
Aaron Kithcart, Boston MA

This list does not reflect temporary changes for this meeting.
American College of Emergency Physicians
Delegate(s)
  Michael D Bishop, Bloomington IN
  Brooks F Bock, Vail CO
  Stephen K Epstein, Boston MA
  Michael J Gerardi, Hackettstown NJ
  John C Moorhead, Portland OR
  Jennifer L Wiler, Aurora CO
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HOUSE OF DELEGATES

2017 Interim Meeting
Notes on Orders of Business

FIRST SESSION, Saturday, November 11, 2:00 – 6:00 pm

SECOND SESSION, Sunday, November 12, 8:00 – 8:30 am

THIRD SESSION, Monday, November 13, 2:00 – 6:00 pm

FOURTH SESSION, Tuesday, November 14, 8:30 am – noon
SUMMARY OF FISCAL NOTES (I-17)

**BOT Report(s)**

01 Redefining the AMA's Position on ACA and Healthcare Reform: Informational report
02 2017 AMA Advocacy Efforts: Informational report
03 Removing Restrictions on Federal Funding for Firearms Violence Research: Informational report
04 Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care: Informational report
05 Effective Peer Review: Modest
06 Electronically Prescribed Controlled Substances Without Added Processes: Minimal
07 Medical Reporting for Safety-Sensitive Positions: Minimal
08 2018 Strategic Plan: Informational report
09 Parental Leave: not yet determined
10 High Cost to Authors for Open Source Peer Reviewed Publications: n/a

**CEJA Opinion(s)**

01 Amendment to E-2.3.2, "Professionalism in the Use of Social Media": n/a

**CEJA Report(s)**

02 Ethical Physician Conduct in the Media:
03 Supporting Autonomy for Patients with Differences of Sex Development (DSD): not yet determined

**CME Report(s)**


**CMS Report(s)**

03 Non-Physician Screening Tests: not yet determined
05 Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding: not yet determined

**CSAPH Report(s)**

01 Universal Color Scheme for Respiratory Inhalers: Minimal
02 Targeted Education to Increase Organ Donation: Minimal
03 Neuropathic Pain as a Disease: Minimal
04 National Drug Shortages Update: Minimal

**Report of the Speakers**

01 Recommendations for Policy Reconciliation: Informational report

**Resolution(s)**

001 Disaggregation of Data Concerning the Status of Asian-Americans: Minimal
002 Intimate Partner Violence Policy and Immigration: Moderate
003 Revision of AMA Policy Regarding Sex Workers: Minimal
004 Tissue Handling: Modest
201 Improving FDA Expedited Approval Pathways: Modest
202 Sexual Assault Survivors’ Rights: Modest
203 Bidirectional Communication for EHR Software and Pharmacies: Modest
SUMMARY OF FISCAL NOTES (I-17)

Resolution(s)

204  EHR Vendors Responsible for Health Information Technology: Modest
205  Health Plan, Pharmacy, Electronic Health Records Integration: Minimal
206  Defending Federal Child Nutrition Programs: Minimal
207  Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs: Modest
208  Increased Use of Body-Worn Cameras by Law Enforcement Officers: Minimal
209  Government Mandated Sequester: Modest
210  Merit-Based Incentive Payment System and Small Practices: Modest
211  Exclusive State Control of Methadone Clinics: Modest
212  Barriers to Price Transparency: Modest
213  APRN Compact: Modest
214  Relieve Burden for Living Organ Donors: Minimal
215  Relationship with US Department of Health and Human Services: Modest
216  Regulations Regarding Medical Tool and Instrument Repair: Minimal
601  Physician Burnout and Wellness Challenges: Minimal
801  Chronic Care Management Payment for Patients Also on Home Health: Modest
802  Opposition to Medicaid Work Requirements: Modest
803  Air Ambulance Regulations and Reimbursements: Modest
804  Prior Authorization: Modest
805  A Dual System for Universal Health Care in the United States: Modest
806  Mandate Transparency by Pharmacy Benefit Managers: Modest
807  Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals: Modest
808  Opposition to Reduced Payment for the 25 Modifier: Moderate
809  Expansion of Network Adequacy Policy: Minimal
810  Pharmacy Benefit Managers and Prescription Drug Affordability: Modest
811  Update OBRA Nursing Facility Preadmission Screening Requirements: Modest
812  Medicare Coverage of Services Provided by Proctored Medical Students: Modest
813  Sustain Patient-Centered Medical Home Practices: Modest
901  Harmful Effects of Screen Time in Children: Minimal
902  Expanding Expedited Partner Therapy to Treat Trichomoniasis: Minimal
903  Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals: Estimated cost to implement resolution is $85,500 to convene experts for 3 one-day session to determine Diagnostic and Treatment Guidelines on Domestic Violence. Estimate includes travel & meeting costs and promotion of guidelines.
904  Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients: Minimal
905  Addressing Social Media Usage and its Negative Impacts on Mental Health: Estimated cost to implement resolution is $375,000 for identification, treatment and referral of at risk individuals. Estimate includes costs to convene collaborator group and development of CME and effective clinical tools and protocols.
906  Opioid Abuse in Breastfeeding Mothers: Modest
907  Addressing Healthcare Needs of Foster Children: Minimal
908  Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability: Minimal
909  Expanding Naloxone Programs: Modest
910  Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination: Modest
952  Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training: Modest
SUMMARY OF FISCAL NOTES (I-17)

Resolution(s)
953 Fees for Taking Maintenance of Certification Examination: Minimal
954 Developing Physician Led Public Health / Population Health Capacity in Rural Communities: Modest
955 Minimization of Bias in the Electronic Residency Application Service Residency Application: Minimal
956 House Physicians Category: Minimal
957 Standardization of Family Planning Training Opportunities in OB-BYN Residencies: Minimal
958 Sex and Gender Based Medicine in Clinical Education: Minimal

Resolutions not for consideration
212 Physician Identification: Minimal
602 Creation of LGBTQ Health Specialty Section Council: No significant fiscal impact
603 A Guide for Best Health Practices for Seniors Living in Retirement Communities: Modest
951 Financial Protections for Doctors in Training: Minimal

Minimal - less than $1,000
Modest - between $1,000 - $5,000
Moderate - between $5,000 - $10,000
Reference Committee on Amendments to Constitution and Bylaws

BOT Report(s)

05  Effective Peer Review
07  Medical Reporting for Safety-Sensitive Positions

CEJA Report(s)

02  Ethical Physician Conduct in the Media
03  Supporting Autonomy for Patients with Differences of Sex Development (DSD)

Resolution(s)

001  Disaggregation of Data Concerning the Status of Asian-Americans
002  Intimate Partner Violence Policy and Immigration
003  Revision of AMA Policy Regarding Sex Workers
004  Tissue Handling
REPORT OF THE BOARD OF TRUSTEES

B of T Report 5-I-17

Subject: Effective Peer Review

Presented by: Gerald E. Harmon, MD, Chair

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

INTRODUCTION

At the 2016 Interim Meeting, the House of Delegates adopted Policy D-375.987, “Effective Peer Review.”

Our AMA study the current environment for effective peer review, on both a federal and state basis, in order to update its current policy to include strategies for promoting effective peer review by physicians and to consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review.

Testimony spoke of the increasing number of physicians who are employed by, or affiliated with, large hospital systems or healthcare organizations, where physicians are concerned that they exert less and less control over their employment and/or practice situations and patient care. As a result, having effective, legitimate peer review processes in place is vital to safeguarding patient care and safety. Further, physicians in the peer review process need protection from retaliation by hospitals and other lay organizations that might be at odds with the role, actions, or decisions taken by those participants. Although the amended language above was originally contained in a resolution, the House of Delegates adopted this language as a “Directive to Take Action.” This report responds to the study requested by AMA Policy D-375.987.

DISCUSSION

AMA Definition of Peer Review

AMA Policy H-375.962, “Legal Protections for Peer Review,” defines peer review, in part, as:

... the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice ... Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care ...

Because peer review can involve close scrutiny of all aspects of patient care and safety, both with respect to organization-wide patient care and safety issues and issues concerning individual physicians and health care practitioners, the peer review process may bring to light serious patient care and safety issues that are systemic to a hospital or other lay organization. Exposure of such
issues could damage the hospital’s or organization’s reputation in its community or its other business interests. Consequently, a physician may be reluctant to participate in a peer review proceeding for fear of retaliation if the physician believes that the hospital or lay organization will take issue with the result of, or the physician’s role in, that proceeding. This fear is exacerbated if the hospital or lay organization dominates the physician’s community. Thus, to ensure effective peer review, physician peer review participants must be protected from the possibility of retaliation.

Market Developments: Physician Employment by Hospitals and Non-physician Entities and Increasing Hospital Consolidation

Physician concerns about retaliation against physician peer review participants have grown as hospitals employ more physicians and hospital markets become more concentrated. Many communities in the United States are dominated by only a few hospitals, or even by a single hospital. As more physicians have become employed by, or affiliated with, dominant hospitals or other powerful lay organizations, some physicians increasingly fear retaliation for expressing patient safety or care concerns during a peer review proceeding, or otherwise participating in a peer review process, that the hospital or organization perceives as being contrary to its financial interests. For employed physicians, employment contract termination may be the greatest concern, since termination may have an immediate and detrimental effect on the physician’s ability to continue practicing medicine in the community, e.g., if the termination triggers a broad restrictive covenant.

Independent physicians may also fear retaliation. Although retaliation against an independent physician would not involve employment termination, retaliation could take other forms, e.g., ending other kinds of contracts with the physician, such as a medical directorship or co-management agreement; attempting to reduce or withdraw the physician’s clinical privileges; manipulating call, surgery, or procedure scheduling; or any other myriad means of making it difficult, if not impossible, to fully and freely utilize hospital facilities and staff. If the hospital dominates the physician’s community, these kinds of retaliatory conduct could make it difficult, if not impossible, for even an independent physician to maintain his or her medical practice in the community.


The Health Care Quality Improvement Act of 1986 (HCQIA), promotes peer review by immunizing those who participate in the peer review process from damages. This immunity applies if a decision by a professional review body, e.g., a decision to revoke hospital privileges, is made using the following standards:

1. In the reasonable belief that the action was in the furtherance of quality health care;
2. After a reasonable effort to obtain the facts of the matter;
3. After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and
4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

Decisions made by a peer review body are presumed to have met standards (1) through (4) above, although this presumption may be rebutted by a preponderance of the evidence.
HCQIA was enacted over 30 years ago, when most physicians practiced independently and hospital markets were not nearly as concentrated as they are today. HCQIA immunity is designed to protect peer reviewers and others who participate in the peer review process, e.g., those who provide information to peer review committees, from damage awards that might result from lawsuits filed by individuals who have been adversely affected by peer review decisions. HCQIA does not explicitly limit immunity from damages solely to lawsuits brought by adversely affected physicians. Consequently, it is possible that a court could interpret HCQIA immunity to extend to damages resulting from lawsuits filed by other parties, e.g., a hospital. However, court decisions have up to this point focused on damage claims by adversely affected physicians, so it is unclear if, and how, HCQIA immunity would apply in the context of lawsuits filed by other parties. Likely a greater concern within the context of AMA Policy D-375.987 is that HCQIA immunity applies when a lawsuit is involved. Consequently, immunity would seem not to apply to a wide variety of retaliatory actions that a hospital or other lay organization might take against a peer reviewer, for example, terminating an employment agreement or hindering an independent physician's ability to fully and freely utilize hospital facilities or practice amenable in association with other physicians employed by, or affiliated with, the hospital or organization.

Amending HCQIA

Although it is possible that an attempt could be made to amend HCQIA to pursue the goals of AMA Policy D-375.987 your Board of Trustees does not, at this time, recommend attempting to amend HCQIA to address a peer review-related retaliation. First, Congressional attention is entirely taken up with a backlog of urgent “must pass” legislation. In this challenging and rapidly changing environment, it would be extremely difficult to draw Congressional attention to yet another major piece of health care legislation, particularly since amending HCQIA has not in recent years been an issue with which Congress has been actively interested. Second, pursuing a HCQIA amendment strategy at this time could have significant, negative unintended consequences, especially with respect to the National Practitioner Data Bank (NPDB). The enactment of HCQIA created the NPDB. In the past, some parties, whose interests are not aligned with those of organized medicine, have strongly urged Congress to amend HCQIA so that the information in the NPDB would be publicly available. Our AMA opposes such efforts. In fact, AMA Policy H-355.976, “National Practitioner Data Bank,” states in part:

. . . 3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee . . .

Our AMA has taken this position because information in the NPDB is often incomplete and inaccurate, not organized in a way that patients will understand, and is thus highly likely to be misunderstood or misinterpreted by patients. For these reasons, then, your Board of Trustees does not recommend attempting to amend HCQIA. However, while your Board does not believe that pursuing a HCQIA amendment would be appropriate at this time, your Board feels strongly that our AMA should provide assistance to any state medical association or national medical specialty society that wants to explore or pursue a state legislative strategy to protect physician peer review participants from retaliation.

Peer Review Immunity under State Law

The vast majority, if not all, states, have enacted peer review immunity laws. The conditions for immunity are usually less demanding or specific compared to HCQIA’s. HCQIA immunity is
available only if a decision by a peer review body satisfies standards (1) through (4) above. Under most state peer review laws, immunity is available to peer review participants who act in good faith.\(^5\) State peer review immunity extends to damages. In some circumstances, states go further, immunizing peer review participants from civil liability generally, which would also protect peer review participants from injunctions.\(^6\)

State peer review laws are designed to protect peer review participants from lawsuits by physicians or health care practitioners who feel that they have been aggrieved by a peer review decision. In many states, immunity protections may not be explicitly limited to lawsuits filed by these individuals. In such cases, like HCQIA, it is uncertain if, or to what extent, immunity would apply if a party other than the individual adversely affected by a peer review decision filed a lawsuit against one or more peer review participants. However, the more important issue with respect to AMA Policy D-375.987 is that, like HCQIA, state peer review immunity protections apply to lawsuits. Consequently, state peer review laws would likely not protect physician peer review participants from the gamut of retaliatory actions short of a lawsuit that might be taken against them for their role in, or a decision resulting from, a peer review proceeding.

Unlike HCQIA, most, if not all, states protect the confidentiality of peer review information. This means that peer review information, documents and records cannot lawfully be disclosed to anyone except those conducting the peer review and any other specific individuals or entities identified in the peer review statute. Similarly, states often privilege peer review information, documents and records of peer review proceedings, meaning that such information, documents and records are not admissible in lawsuits, such as those involving medical liability allegations.

**State Court Decisions**

Although state court decisions involving state peer review statutes have focused on lawsuits by persons adversely affected by a peer review decision, there is a reported case that does involve a situation where a hospital retaliated against a peer review participant. The New Mexico Supreme Court case of Yedidag, MD, v. Roswell Clinic Corp., 346 P.3d 1136 (2015) involved Emre Yedidag, MD, a surgeon employed by Eastern Medical Center (EMC) and his alleged conduct during a peer review proceeding. The proceeding focused on another physician’s role in a patient death. During the proceeding, Dr. Yedidag asked the physician a number of pointed questions to clarify the circumstances of the patient’s death, some of which the physician refused to answer.\(^7\) A staff assistant to the peer review committee, who was not a committee member, attended the meeting and later told hospital administration that Dr. Yedidag’s questioning had been inappropriately aggressive (even though physician peer review committee members found nothing untoward about Dr. Yedidag’s conduct).\(^8\) EMC subsequently fired Dr. Yedidag because of alleged “unprofessional behavior.”\(^9\) Dr. Yedidag sued EMC, claiming that EMC violated New Mexico’s peer review law. The New Mexico Supreme Court sided with Dr. Yedidag. The Court recognized that the New Mexico peer review law did not “explicitly preclude employer retaliation for peer review participation.”\(^10\) Nor did the statute explicitly authorize Dr. Yedidag to file a lawsuit for violations of the peer review law. However, the law did protect the confidentiality of peer review information. The law also permitted use and disclosure of such information only for specific reasons listed in the statute, and those reasons did not include the hospital’s acquisition and use of peer review information as part of its personnel decisions. Consequently, the Court ruled that the hospital violated Dr. Yedidag’s right to confidentiality under New Mexico’s peer review law.

Although Dr. Yedidag won his lawsuit, this decision does not sufficiently address the issues raised by D-375.987. First, the Yedidag case is a single decision under one state’s law. Although most, if not all, states protect the confidentiality of peer review information, state laws can vary
significantly in the scope of this protection. There is, therefore, no guarantee that other states would reach the same result. Second, hospitals and other lay organizations do not necessarily need access to confidential peer review information to retaliate against peer review participants. Thus, even if all states ultimately followed the \textit{Yedidag} decision, doing so would probably not cover all of the instances in which a hospital or other lay organization could retaliate against a physician peer review participant. Consequently, physician advocates wanting to address the issues identified by D-375.987 may want to explore or pursue a state-based legislative strategy to ensure that physician peer review participants are protected from all forms of retaliation.

\textbf{State Legislative Efforts to Protect Physician Peer Review Participants from Retaliation}

While it is extremely unlikely that HCQIA could be successfully amended at this time, the prospects of amending a particular state’s laws might be more promising. Your Board of Trustees understands the serious concerns that AMA Policy D-375.987 raises. Your Board believes, therefore, that our AMA should make its Advocacy Resource Center staff and resources available to assist state medical associations and national medical specialty societies that may be interested in considering or pursuing a state legislative strategy to protect physician peer review participants from any retaliatory conduct by hospitals, lay organizations or other parties.

\textbf{AMA Policy}

AMA policies call for retaliation protections. The following is a list of relevant portions of AMA policies. First, AMA Policy H-225.950, “Principles for Physician Employment,” states, in part, that:

\dots 1.b. [e] mployed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests \dots

Next, AMA Policy H-225.952, “The Physician’s Right to Exercise Independent Judgement in All Organized Medical Staff Affairs,” states that:

[o]ur AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights.

Further, AMA Policy H-230.965, “Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators,” states that:

[t]he AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw
or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics.

AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” asserts, in part, that:

. . . II. Our AMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities: ...b. The right to advocate for its members and their patients without fear of retaliation by the health care organization’s administration or governing body . . .

AMA Policy H-225.942 also contains the following:

. . . IV. Our AMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of employment, contractual, or independent status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the health care organization: ...c. The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the health care organization’s administration or governing body . . .

In addition, AMA Policy H-225.957, “Principles for Strengthening the Physician-Hospital Relationship,” states that:

. . . 6. The organized medical staff has inherent rights of self-governance, which include but are not limited to: ...c) Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws, restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter . . .

Finally, it is notable that our AMA also has policies calling for peer review immunity, two of which are most relevant to this report. First, AMA Policy H-375.962, “Legal Protections for Peer Review,” states, in part, as follows:

. . . Peer Review Immunity. To encourage physician participation and ensure effective peer review, entities and participants engaged in peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability . . .

Likewise, AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” states, in part, that the rights of individual medical staff members must include: “... f. The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities . . .”

Although protection from any kind of retaliation because of peer review participation might be implied from AMA policies, AMA policies do not explicitly call for such protection in the context of peer review participation. This report, therefore, recommends amending AMA Policies H-225.942 and H-375.962 to explicitly include protection from any retaliatory conduct.
RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted per AMA Policy D-375.987, and that the remainder of the report be filed:

1. That AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” be amended by addition as follows:
   
   . . . IV. f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy);

2. That AMA Policy H-375.962, “Legal Protections for Peer Review,” be amended by addition as follows:

   . . . Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities. (Modify Current HOD Policy); and

3. That our AMA will provide guidance, consultation and model legislation concerning protections from retaliation for physician peer review participants, upon request of state medical associations and national medical specialty societies. (Directive to Take Action)

Fiscal Note: $5000.
APPENDIX

D-235.984, “Medical Staff Non-Punitive Reporting Processes”
Our AMA will provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care.

H-285.910, “The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community”
Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community
In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician’s right or ability to advocate on behalf of patients’ interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician’s exercise of his/her rights under this paragraph.

REFERENCES

1 Unlike state peer review laws, HCQIA does not address the confidentiality of peer review information or records of peer review proceedings. Nor does HCQIA address the issue of whether, or to what extent, peer review information, documents, or records may be admitted into lawsuits or administrative proceedings. The Confidentiality and admission of peer review information is determined by courts on a case-by-case basis.
2 See 42 U.S.C. §§ 11101, et seq.
3 42 U.S. Code § 11112(a)
4 Id.
6 Id.
7 Yedidag, at 1143.
8 Id. at 1143-1144.
9 Id. at 1144.
10 Id. at 1151.
Board of Trustees Report 8-I-16, “Medical Reporting for Safety Sensitive Positions,” which sought to address Resolution 14-A-16 of the same title, was referred at the 2016 Interim Meeting of the AMA House of Delegates. Testimony indicated that the report content missed the resolution’s original intent. Although there are systems in place to screen pilots and others in safety sensitive positions for serious medical conditions, it was stated that these patients often look for medical care outside of these systems, and subsequently fail to be reported.

The Board of Trustees conferred with the authors to clarify the intent of Resolution 14-A-16. This report alerts physicians that they may have new responsibilities as a result of changes in regulations of the Federal Aviation Administration (FAA) regarding medical certification of pilots. It addresses the implications of these changes for pilot and public safety.

BACKGROUND

Effective May 1, 2017, pilots of certain small aircraft may elect to participate in the FAA’s new “BasicMed” program, which allows any licensed physician to evaluate a pilot’s medical fitness to fly. If pilots meet conditions for participating in BasicMed, they are no longer required to obtain third class medical certification specifically from an FAA-designated Aviation Medical Examiner (AME) [1]. Pilots in the designated category may continue to seek third class medical certification from an aviation medical examiner if they choose.

To be eligible for privileges in BasicMed, pilots must have a valid U.S. driver’s license, have held third class medical certification at some time since July 15, 2006 (which must not have been revoked, suspended or withdrawn), and not have been denied third class certification on their most recent application [2]. The individual must have documented completion of an FAA-approved online medical education course within the past 24 months; have had a physical examination by a licensed physician, who reviewed the FAA’s Comprehensive Medical Examination Checklist completed by the patient, within the past 48 months; and must consent to a National Driver Register check.

Individuals who have a medical history or clinical diagnosis of personality disorder repeatedly manifested by overt acts, psychosis, bipolar disorder, or substance dependence (within the previous two years) must obtain a “special issuance medical certification” from an aviation medical examiner before they may exercise privileges under BasicMed [2]. Similarly, a history or diagnosis of epilepsy or disturbance of consciousness or transient loss of control of nervous system function absent satisfactory medical explanation of cause entails that the individual obtain a special issuance

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medical certification before he or she may exercise privileges under BasicMed. Further these individuals must be under the care of a physician for the condition.

Individuals are prohibited from exercising privileges under BasicMed if their driver’s license has been revoked as a result of the diagnosed condition or if, “in the judgment of the individual’s state-licensed physician,” the individual is unable or “may reasonably be expected to be unable” to safely exercise those privileges as a result of the condition [2].

PILOT SAFETY — PUBLIC SAFETY

The goal of medical certification, for all classes of pilots, is to ensure public safety. Recent aviation incidents, notably the crash of Germanwings Flight 9525 in 2015, which killed 150 passengers and crew, have raised questions about whether oversight of pilots’ medical status and safety to fly is sufficiently rigorous. FAA requirements covering pilots who fly for commercial airlines, i.e., who hold transport pilot certification, or those who hold commercial pilot certification and may fly for hire, are not affected by the regulatory changes that created BasicMed. Even under the more stringent standards governing these classes of pilots there is concern that pilots with potentially impairing medical conditions may be permitted to fly when they are in fact unsafe [3]. These questions form the backdrop to challenges that BasicMed poses for physicians in the U.S.

Medical Certification of Aviators

Aviation Medical Examiners are specifically authorized by the FAA to carry out pilot medical examinations for purposes of protecting the public. To become an AME, physicians must apply to and complete training developed by the Aerospace Medical Education Division of the FAA Civil Aerospace Medical Institute [4]. Prospective AMEs are required to complete online course work as well as four and a half days of in-person training and to complete refresher training every 36 months [4]. Among other objectives, in-person training is intended to:

- Review the latest medical and technical information and clinical examination techniques in the various medical specialty fields that an AME will need to use to assure that aviators meet the medical certification standards for the class of aviator medical certificate applied for [and]
- Recognize the basis for disqualification of the aviator with a medical problem and the conditions necessitating deferral or denial as outlined in Federal Aviation Regulations [5]

In 2012, the Aerospace Medical Association Ad Hoc Working Group on Pilot Mental Health noted that “serious mental health issues involving sudden psychosis are relatively rare, and their onset is difficult to predict,” but that “more attention should be given to mental health issues during the aeromedical assessment of pilots” [6]. The group recommended that “physicians performing aeromedical assessments receive additional periodic training in aviation mental health issues” [6]. In a letter to the FAA of September 2015 following the report on the Germanwings incident, the working group reiterated its recommendation that more attention be given “to less serious and more common mental health conditions,” including grief, psychosocial stress, depression, anxiety, panic disorders, personality disorders, and substance misuse/abuse, noting that these conditions “show patterns that facilitate early detection, and have proven effective treatment strategies” [6,7]. The working group also reiterated and expanded on its previous recommendation to create a “safe zone” to encourage frank discussion of mental health issues [6], urging that “methods be used to build rapport and trust with the pilot in a nonthreatening environment” [7]. It also more explicitly identified barriers to frank discussion, noting that pilots are “highly independent, value control, and fear losing their medical certification.” The 2015 guidelines reiterated the call for additional
training in aviation mental health issues for physicians who conduct aeromedical assessments, and
called for training to include guidance for when the aeromedical examiner should consult with or
refer the pilot to “a mental health specialist provider or other aeromedical resource.”

The Challenge for Non-AME Physicians

When AMEs who are under contract to commercial air carriers or other commercial entities
conduct examinations of pilot-employees, they are required to report their findings to the pilot’s
employer as well as to the FAA. When they conduct examinations of aviator applicants
independently (i.e., not while under contract to the employer), AMEs must report all findings to the
FAA without fail. In the latter situation, individuals who do not receive medical certification are
expected to voluntarily refrain from piloting aircraft pending further evaluation by FAA medical
experts. On a few occasions the aviator applicants are permanently restricted from medical
certification and cannot legally fly any aircraft.

A pilot exercising the privileges of BasicMed may be examined by any physician licensed by any
U.S. state, territory or possession. The physician is required to report potentially impairing
conditions in keeping with state regulations governing the issuance of motor vehicle licenses. The
examining physician must review the individual’s completed FAA Comprehensive Medical
Examination Checklist with the pilot, but is not required to report to the FAA.

Questions have been raised about how well this process protects both pilots and the public interest.
Non-AME physicians may not be adequately prepared to fulfill this new responsibility. Non-AME
physicians need to be made aware of the responsibility itself and of resources available to them,
including consulting with or referring a patient to a regional Aviation Medical Examiner.

In addition, laws governing reporting of medical conditions that may impair an individual’s ability
to operate a motor vehicle safely vary from state to state. Whether pilots who are eligible for
privileges under BasicMed, but may be impaired, present a greater risk to safety than drivers who
may be impaired is not necessarily at issue. What is of concern are data suggesting that even in
jurisdictions where physicians are required to report potentially impairing conditions for motor
vehicle operators they do not uniformly do so [8].

Confidentiality & Trust

Effective patient-physician relationships require that patients be willing to share sensitive
information with their physicians. Patients must be able to trust that information they give to their
physicians in confidence will be protected, and physicians have a corresponding duty to protect the
confidentiality of patients’ personal information [9–12]. Patients who fear the consequences of
disclosure, particularly disclosure of stigmatizing conditions, may be reluctant to seek treatment.
However, the right to confidentiality is not without limits. In many situations, physicians may be
required to breach confidentiality for purposes of protecting the health or safety of the community,
as in mandatory reporting of infectious disease to public health authorities or required reporting of
potentially impaired drivers [13].

Physicians may also disclose personal health information without patients’ consent when in the
physician’s professional judgment there is a reasonably probability of serious harm to the patient or
serious harm to other identifiable individual(s) [15]. Industry-employed physicians and
independent medical examiners may likewise disclose to third parties [16]. In all instances,
however, physicians are expected to restrict disclosure to the minimum information necessary for
the specific purpose at hand and, whenever feasible, to notify the patient in advance of the
disclosure.

RECOMMENDATION

In light of these considerations, the Board of Trustees recommends that the following be adopted
and the reminder of this report be filed:

1. That our American Medical Association (AMA) promote awareness among all licensed
physicians of the safety implications of mental health and other potentially impairing
conditions for their patients who are aviator. Physicians need to be aware that for some patients
the FAA’s BasicMed program now makes the treating physician a gatekeeper for pilot and
public safety. Physicians who are not FAA Aviation Medical Examiners should be educated
about when to seek guidance from colleagues with aeromedical expertise. Physicians should
also recognize that the range of mental health conditions in particular that may compromise an
aviator’s ability to fly safely is more extensive than the specific conditions identified in the
FAA Comprehensive Medical Examination Checklist. (New HOD Policy)

2. That our AMA urge physicians to screen routinely for factors that may compromise pilot safety
by the least intrusive means reasonable and take steps with the patient to mitigate identified
risks. Physicians should be encouraged to consult with or refer the patient to the appropriate
FAA Aviation Medical Examiner or FAA Regional Flight Surgeon. (New HOD Policy)

3. That our AMA advocate for adoption of a uniform mechanism for reporting aviators who have
potentially compromising medical conditions. (New HOD Policy)

4. That the Council on Ethical and Judicial Affairs be encouraged to review implications for
existing ethics guidance in light of the FAA’s alternative requirements for pilot physical
examination and education codified in BasicMed. (New HOD Policy)

Fiscal Note: Less than $1000.
REFERENCES

Subject: Ethical Physician Conduct in the Media

Presented by: Dennis S. Agliano, MD, Chair

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

Directive D-140.957 (1), “Ethical Physician Conduct in the Media,” adopted at the 2015 HOD Annual Meeting, calls for a report on the professional ethical obligations of physicians in the media. The following analysis by the Council on Ethical and Judicial Affairs (CEJA) addresses ethics concerns in this area and offers guidance for physicians who participate in the media.

PHYSICIANS IN THE PUBLIC SPHERE

Physicians’ knowledge is not confined to the clinical setting. Physicians have well-recognized responsibilities to use their knowledge and skills for the benefit of the community as a whole, whether it is by assisting a state health agency in identifying and tracing infectious disease during an epidemic, advocating for improved health care resources to lessen health disparities, or promoting behaviors that improve the health of communities [1]. Stepping into the media environment can serve as an extension of this public function.

However, the expectations held of physicians as members of the medical profession and of persons in the media are not always compatible. Participation in the media can have unintended consequences for the physician and the medical profession. Information in the public sphere can be sensationalized, misrepresented, or patently falsified, which can have potentially serious consequences if the benefits and drawbacks of medical advice are not appropriately conveyed [2]. Furthermore, physician recommendations may not always reflect the standard of care [3, 4].

A CONTINUUM OF ROLES

Physicians can engage the media in a number of roles. For example, they can serve as conveyors of information or advocates on behalf of public agencies or institutions; as expert consultants on medical science and practice; as commentators on health-related issues of interest to the public; or as journalists covering medicine-related stories. Imagine the following:

Dr. A is head of a health care agency in the federal government. A physician with two decades of public service experience, she is directly responsible for guiding the legislative goals of the agency and is supported by a staff of thousands of federal employees. Dr. A often gives statements to the press about matters under the agency’s jurisdiction, and has, from time to

* Reports of the Council on Ethical and Judicial Affairs are assigned to the Reference Committee on Amendments to Constitution and Bylaws. They may be adopted, not adopted, or referred. A report may not be amended, except to clarify the meaning of the report and only with the concurrence of the Council.
time, participated in press conferences to speak on urgent matters of public health or to make
statements intended to garner greater legislative attention and support.

Dr. B works at an academic medical center. He is frequently approached by media outlets to
comment on recent breakthroughs in medicine or topical issues in medicine and public health
that are making their way through the news cycle. Dr. B also regularly contributes opinion
pieces about medicine and health care policy to news outlets.

Dr. C is a physician whose work has been lauded by practitioners, academics, and celebrities
alike. Recently, she has launched a daytime television program in which she discusses popular
subjects related to medicine, public health, and a general assortment of topics regarding
health and well-being. Dr. C maintains a practice where she sees patients, but the majority of
her time is now spent producing and appearing on her television show.

As a public official, Dr. A uses the media to further a political agenda regarding the health and
well-being of the American public, an agenda she has been tasked with upholding and protecting.
For her, the media is a vehicle to address the needs and concerns of the public, and to keep the
policy goals of her agency at the forefront of awareness among government and private actors
integral to the provision of medical care.

Dr. B is first and foremost an academic physician whose interactions with the media serve a more
consultative function. He generally offers his insight only when approached by the media, although
he may occasionally use his training and experience proactively to shed light on topics when he
feels the public may derive some educational benefit.

In contrast, Dr. C holds herself out to a national audience as a commentator on any number of
subjects falling under the general categories of medicine, health, and wellness—topics that are at
least in part developed by producers and pitched for their ability to boost ratings and increase
viewership. Her audience may or may not know the specifics of her training and experience,
although she uses her medical degree as a symbol of authority and credibility. Moreover, as a
media celebrity, the recommendations she makes on air may be especially persuasive [4].

Whatever role physicians adopt when they participate in the media is very different from that of a
clinical practitioner interacting with individual patients. Whether the medium is print, digital, or
social, physicians who take part in the media marketplace engage in what is fundamentally a
unidirectional relationship with the members of a vast audience who may regard themselves as
patients, but whom the physician will never encounter in person. When a video clip ends or a
reporter stops asking questions, the contact media physicians have with the audience ends. The
hundreds, if not millions, of individuals who have watched, listened, or read have no opportunity to
provide details about their unique medical histories, probe for more guidance about a treatment that
was discussed, or report back to the physician about what effect, if any, the physician’s advice has
had.

FIDELITY, TRUST, AND DIVIDED LOYALTIES

For physicians in the media, then, navigating successfully among the potentially overlapping roles
of clinician, expert consultant, journalist, or (for some) media personality poses challenges. Being
clear about what role(s) they are playing at any given time is crucial [3]. So is being aware of how
media content they create or the media presence they have blurs the lines of medicine, journalism,
and entertainment [3, 5].
For a physician who pursues a distinct career as a singer, a dancer, or a cook on the line in a restaurant kitchen, the new role is entirely different than that of a physician [6]. But when a media career involves depending on the inherent authority of their MD or DO degree rather than their training and skills, physicians in the media are taking advantage of the credibility and prestige bestowed by the public and the media on members of the medical profession [6, 7]. It may never occur to a cancer patient watching a physician on television that “someone highly credentialed might mix critical medical advice with a touch of ‘shock and awe’” even when such behavior might be condemned by other physicians and the medical profession as a whole [7].

Media entities themselves can have diverging interests and goals—winning a Pulitzer or an Emmy for excellence may compete with attracting advertising dollars, viewership, and ratings. Where the latter are the hallmarks of success, the qualifications of physicians who are media personalities, and the quality of the information they are disseminating, can be secondary for producers and audiences [6]. When there is temptation, or pressure, to attract an audience, it can be challenging for physicians to navigate the overlapping roles of health care professional and media personality, and to hold steady to the norms and values of medicine [7].

Trustworthiness and Authoritativeness

By using their medical expertise to reach out to an audience that is local, national, or even global in scale, physicians in the media carry with them heightened expectations as trusted resources, advisors, and representatives of the medical profession. Thus, like physicians in other roles that do not involve directly providing care for patients in clinical settings, physicians in the media should be expected to uphold the values and norms of medicine as a priority [8].

With respect to the recommendations or clinical perspectives a physician contributes to a media forum, such information must be acquired through practical clinical experience or supported by rigorous scientific research that has been carefully vetted within the peer-reviewed literature and presented accurately in the appropriate context [9, 10]. Physicians should likewise be transparent about the limitations of their knowledge or experience in a given area.

A message that is inaccurate, questionable, or false, may still be perceived as authoritative because it comes from a physician [2, 7]. Efforts to correct or recant misinformation from the public forum may prove futile. One contemporary example of this is the still pervasive but false public perception that childhood vaccines are linked to autism, despite the fact that this perception rests on a long-since discredited physician’s publication and there is overwhelming scientific consensus that no such relationship exists [11]. Material that is of poor quality and that does not meet expected standards of scientific rigor can mislead individuals who do not question the content of the message, while the promotion of such subpar work can erode the public’s trust in the larger medical community [7, 12].

Maintaining Privacy in the Public Eye

Physicians working in the media must be cognizant of their work’s impact on patient anonymity, the process of patient consent (concerns of inadvertent coercion), and the potential to exploit patients. They must also make decisions about whether they will present the outcome of a patient case as a fictional representation or as a story of true events [2, 13]. While journalism requires strict adherence to the facts and details of a story, physicians asked to recount a procedure or speak to media about a particular case have a responsibility to obscure or alter details that would reveal a patient’s identity unless the patient freely gave informed consent [13]. Physicians must also remain sensitive to how a story will affect patients under their care, and avoid situations where breaches of
privacy and confidentiality may occur [13, 14, 15]. In the media, physicians may at times need to emulate storytellers rather than journalists [13].

Physicians must exercise caution when they are asked to publicly diagnose celebrities, politicians, or private individuals currently caught in the media’s gaze. Physicians in the media must draw a careful line between using the media to educate the public versus providing a professional opinion when asked to comment on the physical or mental status of a public figure or someone else the physician has not had the opportunity to personally examine [3]. While a sound professional medical opinion reflects a thorough examination of a patient, the clinical history, and all relevant information under the protection of confidentiality, none of this occurs when physicians make casual observations about people [3]. There is a “critical distinction . . . between offering general information about a condition as it pertains to a public figure and rendering a professional opinion about an individual, involving a specific diagnosis, prognosis, or both” [3].

Moreover, physicians may be enticed into offering professional opinion that is outside their individual area of expertise. Physicians who offer expert testimony in court are expected to testify “only in areas in which they have appropriate training and recent, substantive experience and knowledge” [16]. The same expectations should apply to physicians who offer public commentary on health-related matters.

CONFLICTS AND DISCLOSURES

Competing interests are a fact of life for everyone, not only physicians in the media [17]. But as individuals in positions of public trust, media physicians should be especially sensitive to possible conflicts of interest. Even when there is no actual conflict, the appearance of influence or bias can compromise trust in the physician and the broader profession, with downstream consequences for patients and the public.

Taking steps to ensure transparency, independence, and accountability allows media consumers to make informed judgments about the comments or recommendations offered by physicians who are active in the media. Disclosing conflicts of interest is an essential first step [18, 19, 20]. Direct, substantial financial relationships that may influence a physician’s judgment, such as research funding, remuneration for advisory services or speaking engagements, or equity interests in featured products or services, should always be disclosed.

Nonfinancial relationships can also affect judgment and should be disclosed; for example, when a media physician has fiduciary responsibilities to a commercial entity that has an interest in the subject matter. Personal, political, ideological, or intellectual interests can also influence professional judgment in particular situations and media physicians should be prepared to disclose such interests [17, 21, 22].

Disclosure alone is not sufficient, however, and may have the perverse effect of inspiring false confidence on the part of media consumers and even discourage the media physician from rigorously ensuring that he or she is offering objective, unbiased information [23]. In some circumstances, the threat of actual or perceived conflicts of interest may be so great that the only way forward is for the physician to avoid the potential situation altogether.

Instituting measures to promote independent content is a further important step. For example, editorial review of proposed content and presentation can help identify possible bias or the appearance of bias or catch elements that media consumers might be expected to misinterpret. Prohibiting physicians who have clear, unresolved competing interests from being media
spokespersons on issues that involve those interests can likewise help ensure independence [24].

Making explicit to viewers the measures taken to address and mitigate the influence of conflicts of interest will hold media physicians accountable to their peers and the public for exercising sound professional judgment.

CONCLUSION

As trusted members of the community who regularly communicate with the public about health and wellness, physicians have a responsibility to consider their ethical obligations to their patients, the public, and the medical profession. In an increasingly technologically adept media marketplace where the context and delivery of messages are shaped by any number of social and financial forces, physicians must carefully delineate who they are and how they want to be perceived. Equally important, physicians should give thought to how they want to frame and support their messages, and how those messages should be consumed and utilized.

RECOMMENDATION

In light of the foregoing analysis, the Council on Ethical and Judicial Affairs recommends that the following be adopted in lieu of D-140.957(1) and the remainder of this report be filed:

Physicians who participate in the media can offer effective and accessible medical perspectives leading to a healthier and better informed society. However, ethical challenges present themselves when the worlds of medicine, journalism, and entertainment intersect. In the context of the media marketplace, understanding the role as a physician being distinct from a journalist, commentator, or media personality is imperative.

Physicians involved in the media environment should be aware of their ethical obligations to patients, the public, and the medical profession; and that their conduct can affect their medical colleagues, other health care professionals, as well as institutions with which they are affiliated. They should also recognize that members of the audience might not understand the unidirectional nature of the relationship and might think of themselves as patients. Physicians should:

(a) Always remember that they are physicians first and foremost, and must uphold the values, norms, and integrity of the medical profession.

(b) Encourage audience members to seek out qualified physicians to address the unique questions and concerns they have about their respective care when providing general medical advice.

(c) Be aware of how their medical training, qualifications, experience, and advice are being used by media forums and how this information is being communicated to the viewing public.

(d) Understand that as physicians, they will be taken as authorities when they engage with the media and therefore should ensure that the medical information they provide is:

   (i) accurate

   (ii) inclusive of known risks and benefits
(iii) commensurate with their medical expertise

(iv) based on valid scientific evidence and insight gained from professional experience

(e) Confine their medical advice to their area(s) of expertise, and should clearly distinguish the limits of their medical knowledge where appropriate.

(f) Refrain from making clinical diagnoses about individuals (e.g., public officials, celebrities, persons in the news) they have not had the opportunity to personally examine.

(g) Protect patient privacy and confidentiality by refraining from the discussion of identifiable information, unless given specific permission by the patient to do so.

(h) Fully disclose any conflicts of interest and avoid situations that may lead to potential conflicts.

(Fiscal Note: Less than $500)
REFERENCES


At the 2016 Interim Meeting, the American Medical Association (AMA) House of Delegates referred Board of Trustees Report 7-I-16, “Supporting Autonomy for Patients with Differences of Sex Development (DSD),” responding to Resolution 3-A-16 of the same title introduced by the Medical Student Section, which had previously been referred. Resolution 3 asked:

That our AMA affirm that medically unnecessary surgeries in individuals born with differences of sex development are unethical and should be avoided until the patient can actively participate in decision-making.

Testimony regarding BOT 7-I-16 expressed concern about possible unintended consequences and lack of expert insight into the medical complexities in treating differences of sex development in pediatric patients. The Council on Ethical and Judicial Affairs was asked to prepare a report providing ethics guidance in this area.

BACKGROUND

The term “differences of sex development” (DSD), now preferred over “disorders of sex development,” is used to refer to congenital conditions “in which development of chromosomal, gonadal, or anatomic sex is atypical,” broadly encompassing five main groups [1]:

- 46,XX, classical congenital adrenal hyperplasia (CAH);
- 46,XY, a heterogenous set of conditions that includes abnormal androgen steroidogenesis and 5α reductase deficiency;
- varieties of sex chromosome mosaicism, such as mixed gonadal dysgenesis (45,X/46,XY DSD);
- ovo-testicular DSD in which patients present with both ovarian and testicular tissues and abnormally differentiated genital structures; and
- “nonhormonal/nonchromosomal” DSD, represented by abnormal genitalia.

The frequency of DSDs varies with etiology [2,3], but overall incidence of DSD is estimated to be one in 5,500 births [4]. Congenital adrenal hyperplasia accounts for approximately 60 percent of all DSDs [3]. Diagnosis of DSD is complex, encompassing family and prenatal history, physical examination (particularly of genital anatomy), and various laboratory tests, including determination of chromosomal sex. Diagnosis may also involve ultrasound or other imaging studies, hormonal stimulation tests (e.g., human chorionic gonadotropin or adrenocorticotropic stimulation), and, in
rare cases, laparotomy or laparoscopy [4]. Some 60 percent of affected children are now diagnosed prenatally [4].

DSD include potentially life-threatening developmental anomalies that may require immediate intervention, for example, hypotension resulting from salt-wasting nephropathy, which occurs in 75 percent of infants born with congenital adrenal hyperplasia. DSD also include “cosmetic” abnormalities for which elective interventions to normalize appearance can be undertaken at various stages in the child’s life [3,5].

Early diagnosis is essential to identify and intervene in life-threatening conditions. Historically, treatment for DSD also gave high priority to medically assigning gender in a newborn with ambiguous genitalia under what became known as an “optimal gender policy” intended to “facilitate stable gender identity and appropriate gender role behavior” [5]. This approach recommended early surgery to match genitalia to assigned gender, on the rationale that uncertain gender is distressing for the family, may adversely affect the child’s mental health, and can lead to stigmatization [4,5,6]. This view has been increasingly challenged [5,7]. DSD communities and a growing number of health care professionals have condemned such genital “normalizing,” arguing that except in the rare cases in which DSD presents as life-threatening anomalies, genital modification should be postponed until the patient can meaningfully participate in decision making [5,8,9,10].

In 2006, the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) observed that “[m]uch of the clinical challenge intrinsic to pediatric urology rests in the need to discriminate between children at risk for severe long-term complications and requiring intervention and the larger group who are not. The report noted the lack of sufficient data to guide decisions about gender assignment and absence of clear guidelines for clinical practice, particularly in light of concerns about the irreversibility of surgical intervention and possible sensory damage to the genitalia [11]. The NIDDK cited the lack of “systematic outcome data about sexual function in individuals with disorders of sexual differentiation [sic]” and of data “pertaining to the association of sexual function with genital appearance and types of genital surgery.” It concluded that “it is unclear whether gender identity requires gender-consistent genital appearance” and urged prospective studies of gender identity, reproductive function, and quality of life for patients with DSD [11].

A decade later, outcomes data remain limited. A small study carried out in 2011–2012 among medical students in Zurich found that how physicians discussed treatment for a child with DSD influenced the choice for or against surgery [12]. Participants watched brief counseling videos that described DSD either as a condition that is static, has an inherent psychosocial component, and requires treatment, and for which predetermined treatment regimens focus on biological function, or as a dynamic disorder characterized by context-dependent impairment for which coping strategies should be fostered, with treatment geared to the individual’s interests and capabilities. Sixty-six percent of participants who viewed the medicalized video said they would choose early surgery for their child, compared to 23 percent of those who viewed the demedicalized video. In a systematic review of follow-up of psychological outcomes of intervention for patients with DSD published in 2015, Brazilian researchers found a lack of prospective long-term evaluations of psychological outcomes of sex assignment surgery [13]. They noted concerns about the quality of published studies, citing variable sample size, inconsistent methodologies, and poorly defined outcome measures.
NEW PARADIGMS FOR TREATMENT

In addition to the NIDDK report questioning the “optimal gender” policy, in 2006 both the Intersex Society of North America (ISNA) and the International Consensus Conference on Intersex released guidelines on the management of DSD that urged a more conservative approach [1,14]. ISNA guidelines note that gender assignment “is a social and legal process not requiring medical or surgical intervention” (original emphasis) [ISNA 2006]. The guidelines recommend delaying elective surgical and hormonal treatments until the patient can participate in decision making and caution that health care professionals must distinguish between offering medically needed treatment to benefit the child and offering treatment to allay parental anxiety. Like the ISNA, the consensus statement of the International Consensus Conference on Intersex recommended deferring elective interventions and similarly urged that care be provided by a multidisciplinary team. In 2016 the Global DSD Update Consortium reviewed developments over the preceding decade, noting particularly the important role that peer support can play in helping parents, and children, make informed decisions about elective treatment [15].

In its 2017 report on the rights of children in biomedicine, the Bioethics Committee of the Council of Europe observed that, based its review of on available scientific evidence, only three interventions meet criteria of being “medically necessary”: “(1) administration of endocrine treatment to prevent fatal salt-loss in some infants, (2) early removal of streak gonads in children with gonadal dysgenesis, and (3) surgery in rare cases to allow extrophic conditions in which organs protrude from the abdominal wall or impair excretion” [16]. However, these recommendations remain controversial and there is not yet consensus in the medical community. Recent interviews carried out by Human Rights Watch among individuals with DSD examine patient experience and underscore the value of organizing dedicated multidisciplinary care teams [17].

In educational material for parents, the American Academy of Pediatrics likewise stresses multidisciplinary care and notes that, if not medically necessary, “any irreversible procedure can be postponed until the child is old enough to agree to the procedure (e.g., genital surgery)” [18].

CURRENT AMA POLICY

Current AMA policy does not address treatment for patients with DSD directly. Rather, a limited number of ethics and House policies speak to decisions for minors more broadly, as well as to issues pertaining to gender identity, sexual orientation, transgender health, and discrimination toward sexual minority communities:

- **Opinion 2.2.1**, “Pediatric Decision Making,” encourages involving minor patients in decision making at a developmentally appropriate level, including decisions that involve life-sustaining interventions, and recommends that physicians work with parents or guardians to simplify complex treatment regimens for children with chronic health conditions.

- **Opinion 2.2.4**, “Treatment Decisions for Seriously Ill Newborns,” articulates the considerations that must be taken into account when addressing emotionally and ethically challenging cases involving newborns, including: the medical needs of the child; the interests, needs, and resources of the family; available treatment options; and respect for the child’s right to an “open future.” It calls on physicians to inform parents about available therapeutic options and the nature of those options and to discuss the child’s expected prognosis with and without intervention.
• **Opinion 2.2.5**, “Genetic Testing of Children,” identifies conditions under which physicians may ethically offer genetic testing for minor patients. It observes that testing implicates important concerns about the autonomy and best interests of the minor patient and holds that medical decisions made on behalf of a child should not abrogate the opportunity to choose to know his or her genetic status as an adult.

**DECISIONS FOR PEDIATRIC PATIENTS**

Parents (or guardians) are granted the authority to make health care decisions for their minor children when the child lacks the ability to act independently or does not have the capacity to make medical decisions [19]. Parents are deemed to be in a better position than others to understand their child’s unique needs and interests, as well as their family’s, and thus to be able to make appropriate decisions regarding their child’s health care. Historically, the best interest standard has predominated as the appropriate decision-making standard for medical decisions for minors. Current consensus rests on a more nuanced view that encompasses not only the patient’s medical interests, but psychosocial and familial concerns as well [19].

The “harm principle” has been suggested as a further refinement on the decision-making standard, requiring not only that decision makers consider the patient’s best interests, broadly understood, but also that a threshold of harm be identified, below which decisions should not be tolerated [19]. Parents (or guardians) are also recognized to have a responsibility to foster their children’s autonomy and moral growth, a responsibility clinicians share. Providing information in a developmentally appropriate way that respects the minor patient’s cognitive ability, engaging the child in decision making to the extent possible, and seeking the child’s assent to proposed interventions helps to fulfill that responsibility [19].

With respect to DSD specifically, suggested broad principles to guide decisions about elective interventions have been suggested. Proposals emphasize the need to balance leaving future options open [9] and upholding the child’s right to participate in decision making [5] with respect for parents’ wishes and family relationships. Likewise, they concur that decisions for patients with DSD should focus on promoting the well-being of the child and future adult [5], including minimizing physical and psychosocial risks to the child, preserving potential for fertility, and preserving capacity for satisfying sexual relations [9].

In cases of DSD, decisions about a child’s best interests and appropriate interventions involve sensitive issues of sex, gender, and sexuality, and interventions that may be irreversible. Parents are often concerned about the future well-being of their child with regard to self-identity, relationships, and reproductive capacity [8]. Because of these concerns, they may be quick to want to establish sex and gender identity for their child in order to promote “normalcy” and reduce stigmatization. Moreover, when physicians perceive early intervention to be urgently needed or wholly beneficial, they may not fully recognize that there is a decision to be made, or the complexity of that decision for the family and patient.

A 2013 lawsuit, though unsuccessful, raised constitutional issues with respect to early surgical intervention and sex assignment. In 2013, the adoptive parents of a South Carolina child, MC, born with “ovotesticular DSD” filed suit in the US District Court for the District of South Carolina against physicians who had performed feminizing genitoplasty on the child at age 16 months. At the time of surgery, MC was under the legal custody of the South Carolina Department of Social Services, which authorized the intervention. Despite initially being raised as a girl by his adoptive parents, consistent with his surgically assigned sex, MC identified as a boy and at the time the lawsuit was filed was living as a boy. Because of the surgery, MC is now sterile. Although the
action was dismissed on appeal by the US Court of Appeals for the Fourth Circuit (in January 2015) [20], the lower court had denied the defendants’ request for dismissal on the grounds that the defendants may have violated MC’s constitutional right to procreate [21]. In July 2017, the Medical University of South Carolina denied all claims and liability, but agreed to a settlement with the family [22].

RECOMMENDATION

The Council on Ethical and Judicial Affairs recommends that Opinion E-2.2.1, “Pediatric Decision Making,” be amended as follows in lieu of Resolution 3-A-16 and the remainder of this report be filed:

Unlike health care decisions for most adult patients, decisions for pediatric patients usually involve a three-way relationship among the minor patient, the patient’s parents (or guardian), and the physician. Although children who are emancipated may consent to care on their own behalf, in general, children below the age of majority are not considered to have the capacity to make health care decisions on their own. Rather, parents or guardians are expected, and authorized, to provide or decline permission for treatment for minor patients. Nonetheless, respect and shared decision making remain important in the context of decisions for minors, and physicians have a responsibility to support the child’s emerging autonomy and should engage minor patients in making decisions about their own care to the greatest extent possible, including decisions about life-sustaining treatment.

Decisions made for pediatric patients should seek to foster the well-being of children and the adults they will become. Physicians should provide information and other resources to support parents or guardians in making decisions about their child’s care and should individualize treatment to promote the child’s best interest, which is determined by weighing many factors, including effectiveness of available appropriate medical therapies and the needs and interests of the patient and the family as the source of support and care for the patient.

Parents or guardians must also assess whether the decision made for a minor patient will abrogate a choice the future individual would want to make for him- or herself. Except when immediate treatment is medically necessary to preserve life or avert serious and irreversible harm, physicians should support parents’ efforts to make decisions that do not undermine the child’s right to an “open future.” When there is legitimate inability to reach no consensus in the field about what is in the best interest of the child, the wishes of the parents/guardian should generally receive preference.

For health care decisions involving minor patients, physicians should:

(a) Involve all patients in decision making at a developmentally appropriate level.

(b) Base recommendations for treatment on the likely benefit to the patient, taking into account the effectiveness of treatment, risks of additional suffering with and without treatment, available alternatives, and overall prognosis as indicated by the best available scientific evidence. Where there are questions about the efficacy or long-term impact of treatment alternatives, physicians should encourage ongoing collection of data to help clarify the value to patients of different approaches to care.
(c) For patients capable of assent, truthfully explain the medical condition, its clinical implications, and the treatment plan in a manner that takes into account the child’s cognitive and emotional maturity and social circumstances for patients capable of assent.

(d) Provide a supportive environment to promote the well-being of both the patient and the family and encourage parents to discuss their child’s health status with the patient. Offer to facilitate the parent-child conversation for reluctant parents.

(e) Recognize that for certain medical conditions, such as those involving HIV/AIDS, or inherited conditions, or developmental anomalies, may involve highly sensitive information. Disclosing the child’s health status may also reveal health information about biological relatives, or disrupt relationships within the family, or lead to stigma or discrimination. Physicians should offer education and support to help minimize the psychosocial impact of such conditions for the child and the family.

(f) Work with parents/guardians to simplify complex treatment regimens whenever possible and educate parents in ways to avoid behaviors that put the child or others at risk.

(g) Ensure that when decisions involve life-sustaining interventions, ensure that patients have opportunity to be involved in keeping with their ability to understand decisions and their desire to participate. Physicians should ensure that the patient and parents/guardian understand the patient’s diagnosis, both with and without treatment. Physicians should discuss with the patient and parents/guardian the option of initiating an intervention with the intention of evaluating its clinical effectiveness after a specified amount of time to determine if it has led to improvement. Confirm that if the intervention has not achieved agreed-on goals it may be withdrawn.

(h) Respect the decisions of the patient and parents/guardian when it is not clear whether a specific intervention promotes the patient’s best interests.

(i) Seek consultation with an ethics committee or other institutional resource when:

   (i) there is a reversible life-threatening condition and the patient (if capable) or parents/guardian refuse treatment the physician believes is clearly in the patient’s best interest; or

   (ii) there is disagreement about what the patient’s best interests are. Physicians should turn to the courts to resolve disagreements only as a last resort.

(j) Provide compassionate and humane care to all pediatric patients, including patients who forgo or discontinue life-sustaining interventions.

(Modify Current HOD/CEJA Policy)

Fiscal Note: Less than $500
REFERENCES


Whereas, The pan-ethnic, umbrella term "Asian-American" masks the significant disparities in health outcomes and socioeconomic realities as well as undermines efforts for increased inclusion and representation of students from under-represented Asian countries and cultures, especially in individuals from Laotian, Cambodian, Indonesian, and other backgrounds;\(^1\),\(^2\),\(^3\) and

Whereas, While Chinese American and Asian Indian Americans experience relatively low aggregate poverty rates, at 12.2% and 8.5% respectively, the ethnic groups with the most people in poverty in 2010 were Chinese Americans, with 449,356 people living in poverty, and Asian Indian Americans, with 246,399 people living in poverty, primarily due to the large size of their populations;\(^4\) and

Whereas, The 2006 to 2010 aggregate poverty rate by population group was reported as 65% of Bhutanese Americans, 27% for Hmong Americans, and 21% for Bangladeshi Americans;\(^4\),\(^5\),\(^6\) and

Whereas, AB-1726 became law in California, requiring that the Department of Public Health collect disaggregate demographic data to better expose disparities in health care for Pacific Islanders and Southeast Asians, serving as an example for other states to model;\(^7\),\(^8\) and

Whereas, Pursuant to AMA Policy H-350.966, the AMA urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders; therefore be it

RESOLVED, That our American Medical Association support the disaggregation of data regarding Asian-Americans in order to reveal the within-group disparities that exist in health outcomes and representation in medicine. (New HOD Policy)

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

Received: 09/20/17

RELEVANT AMA POLICY

Health Initiatives on Asian-Americans and Pacific Islanders H-350.966
Our AMA urges existing federal agencies, commissions and Asian American and Pacific Islander health organizations to study how to improve the collection, analysis and dissemination of public health data on Asian Americans and Pacific Islanders.
Res. 404, A-00 Reaffirmed: CSAPH Rep. 1, A-10

See also:
Medical Education for Members in Underserved Minority Populations H-350.969
Underrepresented Student Access to US Medical Schools H-350.960
Reducing Racial and Ethnic Disparities in Health Care D-350.995
Diversity in Medical Education H-350.970
Improving the Health of Black and Minority Populations H-350.972
Racial and Ethnic Disparities in Health Care H-350.974
Minorities in the Health Professions H-350.978
Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities D-350.991
Addressing Immigrant Health Disparities H-350.957
Improving the Health of Minority Populations H-350.961
Cancer and Health Care Disparities Among Minority Women D-55.997
Strategies for Eliminating Minority Health Care Disparities D-350.996
Whereas, Most states in the United States have enacted mandatory reporting laws regarding domestic violence, which require the reporting of specified injuries and wounds and suspected abuse or domestic violence for individuals being treated by a health care professional; and

Whereas, Reports have shown that stated goals of mandated reporting policy of enhancing patient safety, improving health care providers’ response to domestic violence, holding perpetrators accountable, and improving domestic violence data collection and documentation mitigate access to and quality of healthcare delivery; and

Whereas, The laws vary from state-to-state, but generally fall into four categories: states that require reporting of injuries caused by weapons; states that mandate reporting for injuries caused in violation of criminal laws, as a result of violence, or through non-accidental means; and

Whereas, Three states have exceptions for reporting injuries due to domestic violence (New Hampshire, Oklahoma, and Pennsylvania); and

Whereas, Our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims of intimate partner violence if the required reports identify victims; and

Whereas, Current AMA policy states if and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims’ identities; (b) allow competent adult victims to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws; and

Whereas, It has been reported that immigrant women and girls are highly vulnerable to abuse and are statistically twice as likely as non-immigrant females to experience domestic violence; and

Whereas, There are reports that undocumented domestic violence victims are fearful of seeking healthcare due to concerns of immigration authority involvement; and

Whereas, Current AMA policy does not specify the use of mandated reporting policies with regard to immigration; and
Whereas, The AMA’s “Diagnostic and Treatment Guidelines on Domestic Violence”, which provided guidance for Interviewing, Diagnosis, Interventions, Documentation, and Risk management regarding domestic violence related care was last updated in 1992 and does not reflect current best practices; therefore be it

RESOLVED, That our American Medical Association encourage appropriate stakeholders to study the impact of mandated reporting of domestic violence policies on individuals with undocumented immigrant status and identify potential barriers for survivors seeking care (Directive to Take Action); and be it further

RESOLVED, That our AMA work with community based organizations and related stakeholders to clarify circumstances that would trigger mandated reporting of intimate partner violence and provide education on the implications of mandatory reporting on individuals with undocumented immigrant status. (Directive to Take Action)

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

Received: 09/28/17

RELEVANT AMA POLICY

Gender-Based Violence H-65.974
Our AMA: (1) opposes inhumane treatment of people of both genders; and (2) encourages the development of programs to educate and alert all cultures to remaining practices of inhumane treatment based on gender and promote recognition of abusive practices and adequate health care for victims thereof.

Citation: Res. 404, A-06; Modified: CSAPH Rep. 01, A-16

Patient and Physician Rights Regarding Immigration Status H-315.966
Our AMA supports protections that prohibit U.S. Immigration and Customs Enforcement, U.S. Customs and Border Protection, or other law enforcement agencies from utilizing information from medical records to pursue immigration enforcement actions against patients who are undocumented.

Citation: Res. 018, A-17

See also: Family and Intimate Partner Violence H-515.965; Preventing, Identifying and Treating Violence and Abuse E-8.10

References:
Whereas, The terms “prostitute” and “prostitution” are now considered pejorative labels for individuals who exchange sex for money or goods; and

Whereas, The medical, public health, and research communities currently utilize the terms “sex work” and “sex workers” to refer to the practice and individuals who exchange sex for money or goods;\(^1\) and

Whereas, It remains important for our AMA to utilize the most current terminology accepted in the medical and public health communities; and

Whereas, Our AMA has policy discussing sex workers, but this policy utilizes terminology that is considered outdated and carries a negative connotation towards these individuals; and

Whereas, Sex work carries a significant stigma that requires continued attention from the medical and public health communities, and which acts as a strong deterrent against sex workers seeking appropriate and compassionate medical care; and

Whereas, Sex workers face numerous public health detriments, including, but not limited to, violence at the hands of clients and police personnel\(^2\), psychiatric/mental health issues, sexually transmitted infections, drug abuse and addiction, personal hygiene, and poor access to health care;\(^3\) and

Whereas, Epidemiological and prevalence studies from varied urban and geographical centers report the number of sex workers with concurrent HIV infection to range from 9-33%, depending on the location and population studied;\(^4,5,6,7\) and

Whereas, It is predicted that aversion of up to 46% of new HIV infections worldwide could be attained by the decriminalization of sex work and the amelioration of stigma associated with this work;\(^8\) therefore be it


RESOLVED, That our American Medical Association amend the text of HOD Policy H-20.898, “Global HIV/AIDS Prevention,” by addition and deletion to read as follows:

H-20.898 Global HIV/AIDS Prevention
Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to prostitution sex work (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend the text of HOD Policy H-20.922, “HIV/AIDS as a Global Public Health Priority,” by addition and deletion to read as follows:

H-20.922 HIV/AIDS as a Global Public Health Priority
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes commercial sex;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic.
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services (Modify Current HOD Policy); and be it further
RESOLVED, That our AMA amend the title and text of HOD Policy H-515.958, “Promoting Safe Exit from Prostitution,” by addition and deletion to read as follows:

H-515.958 Promoting Safe Exit from Prostitution Sex Work
Our American Medical Association supports efforts to offer individuals opportunities to a safe exit from prostitution and work safely if they choose to do so, as well as access to in pursuit of compassionate care and “best practices”-based services whether or not they choose to continue in sex work. Our American Medical Association also supports legislation for programs that prevent and divert prostitution rather than penalize individuals arresting on sex work charges.

Passed: 11/28/17
Fiscal Note: Minimal - less than $1,000.
Received: 09/29/17

RELEVANT AMA POLICY

Global HIV/AIDS Prevention H-20.898
Our AMA supports continued funding efforts to address the global AIDS epidemic and disease prevention worldwide, without mandates determining what proportion of funding must be designated to treatment of HIV/AIDS, abstinence or be-faithful funding directives or grantee pledges of opposition to prostitution.
Citation: Res. 439; A-08

HIV/AIDS as a Global Public Health Priority H-20.922
In view of the urgent need to curtail the transmission of HIV infection in every segment of the population, our AMA:
(1) Strongly urges, as a public health priority, that federal agencies (in cooperation with medical and public health associations and state governments) develop and implement effective programs and strategies for the prevention and control of the HIV/AIDS epidemic;
(2) Supports adequate public and private funding for all aspects of the HIV/AIDS epidemic, including research, education, and patient care for the full spectrum of the disease. Public and private sector prevention and care efforts should be proportionate to the best available statistics on HIV incidence and prevalence rates;
(3) Will join national and international campaigns for the prevention of HIV disease and care of persons with this disease;
(4) Encourages cooperative efforts between state and local health agencies, with involvement of state and local medical societies, in the planning and delivery of state and community efforts directed at HIV testing, counseling, prevention, and care;
(5) Encourages community-centered HIV/AIDS prevention planning and programs as essential complements to less targeted media communication efforts;
(6) In coordination with appropriate medical specialty societies, supports addressing the special issues of heterosexual HIV infection, the role of intravenous drugs and HIV infection in women, and initiatives to prevent the spread of HIV infection through prostitutes;
(7) Supports working with concerned groups to establish appropriate and uniform policies for neonates, school children, and pregnant adolescents with HIV/AIDS and AIDS-related conditions; and
(8) Supports increased availability of anti-retroviral drugs and drugs to prevent active tuberculosis infection to countries where HIV/AIDS is pandemic.
(9) Supports programs raising physician awareness of the benefits of early treatment of HIV and of "treatment as prevention," and the need for linkage of newly HIV-positive persons to clinical care and partner services.
Citation: CSA Rep. 4, A-03; Reaffirmed: Res. 725, I-03; Reaffirmed: Res. 907, I-08; Reaffirmation I-11; Appendix: Res. 516, A-13; Reaffirmation I-13; Reaffirmed: Res. 916, I-16

Promoting Safe Exit from Prostitution H-515.958
Our American Medical Association supports efforts to offer individuals a safe exit from prostitution in pursuit of compassionate care and best practices and supports legislation for programs that prevent and divert prostitution rather than penalize them through criminal conviction and incarceration.
Citation: Res. 14, A-15
Whereas, There appears to be a movement to pass laws requiring the handling of tissue obtained from the termination of a pregnancy differently than other tissues obtained during a medical procedure; and

Whereas, These laws propose to require the interment of fetal tissue obtained from the termination of a pregnancy; and

Whereas, The implementation of these laws has practical implications for patients, health care facilities, and physicians; and

Whereas, There appears to be no scientific basis for differing requirements; therefore be it

RESOLVED, That our American Medical Association adopt policy stating that fetal tissue obtained during the termination of a pregnancy should be handled no differently than other tissues obtained during a medical procedure (New HOD Policy); and be it further

RESOLVED, That our AMA strongly oppose any proposed laws or regulations that would require the handling of fetal tissue obtained during the termination of a pregnancy differently than other tissues obtained during a medical procedure. (Directive to Take Action)

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

Received: 09/29/17

RELEVANTAMA POLICY

Right to Privacy in Termination of Pregnancy H-5.993
The AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.
Citation: (Res. 49, I-89; Reaffirmed by Sub. Res. 208, I-96; Reaffirmed by BOT Rep. 26, A-97; Reaffirmed: Sub. Res. 206, A-04; Reaffirmed: CCB/CLRPD Rep. 2, A-14)

Pregnancy Termination H-5.983
The AMA adopted the position that pregnancy termination be performed only by appropriately trained physicians (MD or DO).
Citation: (Res. 520, A-95; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)
E-7.3.5 Research Using Human Fetal Tissue

Research with human fetal tissue research has led to the development of a number of important research and medical advances, such as the development of polio vaccine. Fetal tissue has also been used to study the mechanism of viral infections and to diagnose viral infections and inherited diseases, as well as to develop transplant therapies for a variety of conditions, for example, parkinsonism. However, the use of fetal tissue for research purposes also raises a number of ethical considerations, including the degree to which a woman's decision to have an abortion might be influenced by the opportunity to donate fetal tissue. Concerns have also been raised about potential conflict of interest when there is possible financial benefit to those who are involved in the retrieval, storage, testing, preparation, and delivery of fetal tissues.

To protect the interests of pregnant women as well as the integrity of science, physicians who are involved in research that uses human fetal tissues should:
(a) Abstain from offering money in exchange for fetal tissue.
(b) In all instances, obtain the woman's voluntary, informed consent in keeping with ethics guidance, including when using fetal tissue from a spontaneous abortion for purposes of research or transplantation. Informed consent includes a disclosure of the nature of the research including the purpose of using fetal tissue, as well as informing the woman of a right to refuse to participate.
(c) Ensure that when fetal tissue from an induced abortion is used for research purposes:
   (i) the woman's decision to terminate the pregnancy is made prior to and independent of any discussion of using the fetal tissue for research purposes;
   (ii) decisions regarding the technique used to induce abortion and the timing of the abortion in relation to the gestational age of the fetus are based on concern for the safety of the pregnant woman.
(d) Ensure that when fetal tissue is to be used for transplantation in research or clinical care:
   (i) the donor does not designate the recipient of the tissue;
   (ii) both the donor and the recipient of the tissue give voluntary, informed consent.
(e) Ensure that health care personnel involved in the termination of a pregnancy do not benefit from their participation in the termination, or from use of the fetal tissue for transplantation.

AMA Principles of Medical Ethics: I, III, IV, V

E-7.3.4 Maternal-Fetal Research

Maternal-fetal research, i.e., research intended to benefit pregnant women and/or their fetuses, must balance the health and safety of the woman who participates and the well-being of the fetus with the desire to develop new and innovative therapies. One challenge in such research is that pregnant women may face external pressure or expectations to enroll from partners, family members, or others that may compromise their ability to make a fully voluntary decision about whether to participate.

Physicians engaged in maternal-fetal research should demonstrate the same care and concern for the pregnant woman and fetus that they would in providing clinical care.

In addition to adhering to general guidelines for the ethical conduct of research and applicable law, physicians who are involved in maternal-fetal research should:
(a) Base studies on scientifically sound clinical research with animals and nongravid human participants that has been carried out prior to conducting maternal-fetal research whenever possible.
(b) Enroll a pregnant woman in maternal-fetal research only when there is no simpler, safer intervention available to promote the well-being of the woman or fetus.
(c) Obtain the informed, voluntary consent of the pregnant woman.
(d) Minimize risks to the fetus to the greatest extent possible, especially when the intervention under study is intended primarily to benefit the pregnant woman.

AMA Principles of Medical Ethics: I, III, V

Fetal Tissue Transplantation Research H-5.992

Our AMA (1) supports continued research employing fetal tissue obtained from induced abortion, including investigation of therapeutic transplantation; and (2) demands that adequate safeguards be taken to isolate decisions regarding abortion from subsequent use of fetal tissue, including the anonymity of the donor, free and non-coerced donation of tissue, and the absence of financial inducement.

Citation: (Res. 170, I-89; Reaffirmed by Res. 91, A-90; Modified: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10)

Use of Fetal Tissue for Legitimate Scientific Research H-5.994

The AMA supports (1) the concept of the use of fetal tissue for legitimate scientific research, including transplantation; and (2) continued federal funding for such research.

Citation: (Res. 26, I-88; Reaffirmed: Res. 91, A-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CEJA Rep. 6, A-10)

Fetal Tissue Research H-5.985

The AMA supports the use of fetal tissue obtained from induced abortion for scientific research.

Citation: (Res. 540, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)
BOT Report(s)

06 Electronically Prescribed Controlled Substances Without Added Processes

Resolution(s)

201 Improving FDA Expedited Approval Pathways
202 Sexual Assault Survivors’ Rights
203 Bidirectional Communication for EHR Software and Pharmacies
204 EHR Vendors Responsible for Health Information Technology
205 Health Plan, Pharmacy, Electronic Health Records Integration
206 Defending Federal Child Nutrition Programs
207 Redistribution of Unused Prescription Drugs to Pharmaceutical Donation and Reuse Programs
208 Increased Use of Body-Worn Cameras by Law Enforcement Officers
209 Government Mandated Sequester
210 Merit-Based Incentive Payment System and Small Practices
211 Exclusive State Control of Methadone Clinics
213 Barriers to Price Transparency
214 APRN Compact
215 Relieve Burden for Living Organ Donors
216 Relationship with US Department of Health and Human Services
217 Regulations Regarding Medical Tool and Instrument Repair
INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 216-A-17, “Electronically Prescribed Controlled Substances without Added Processes,” was referred for report at the 2017 Interim Meeting. Resolution 216-A-17, sponsored by the Illinois Delegation Association, asks our American Medical Association (AMA) to advocate for full electronic prescribing of all prescriptions, without additional cumbersome electronic verification, including Schedule II-V controlled substances, eliminating the need for “wet signed” paper prescriptions and faxes for specific classes of prescriptions. The reference committee heard testimony strongly supportive of the intent of Resolution 216. The reference committee noted that current Drug Enforcement Administration (DEA) requirements for biometric devices limit user-friendly consumer electronics already found in physicians’ offices, such as fingerprint readers on laptop computers and mobile phones, from being used for two-factor authentication in Electronically Prescribed Controlled Substances (EPCS). The reference committee acknowledged the frustration heard in testimony regarding how two-factor authentication and other rules contribute to cumbersome workflows and applications and noted that EPCS uptake is slow precisely due to these barriers. The reference committee also heard testimony that our AMA continues to have discussions with key stakeholders to work toward improving the integration of EPCS and the interoperability of Prescription Drug Monitoring Programs (PDMP) and electronic health records into practice workflows and clinical decision-making. The reference committee noted that our AMA has made and continues to make these points at both the federal and state levels.

AMA POLICY

Current AMA policy provides:


Our American Medical Association will address with the Centers for Medicare & Medicaid Services and the Drug Enforcement Administration the contradictory guidance, issued respectively by those two federal agencies, relating to electronic transmission of physicians prescriptions to pharmacies—commonly referred to as “e-prescribing”—for Schedules III, IV and V drugs, as those current guidelines add rather than reduce administrative paperwork and defeat the purpose of electronic handling of prescriptions.

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Policy D-120.958, “Federal Roadblocks to E-Prescribing”
1. Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, "brand medically necessary" on a paper prescription form. 2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs. 3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of E-prescribing. 4. Our AMA will work with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions. 5. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption. 6. Our AMA will: (A) investigate regulatory barriers to electronic prescription of controlled substances so that physicians may successfully submit electronic prescriptions for controlled substances; and (B) work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-Prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply. 7. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications. 8. Our AMA will petition the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished.

Policy H-120.957, “Prescription of Schedule II Medications by Fax and Electronic Data Transmission”
Our AMA: (1) encourages the Drug Enforcement Administration to rewrite Section 1306 of Title 21 of the Code of Federal Regulations to accommodate encrypted electronic prescriptions for Schedule II controlled substances, as long as sufficient security measures are in place to ensure the confidentiality and integrity of the information. (2) Our AMA supports the concept that public key infrastructure (PKI) systems or other signature technologies designed to accommodate electronic prescriptions should be readily adaptable to current computer systems, and should satisfy the criteria of privacy and confidentiality, authentication, incorruptibility, and nonrepudiation. (3) Because sufficient concerns exist about privacy and confidentiality, authenticity, and other security measures, the AMA does not support the use of "hard copy" facsimile transmissions as the original written prescription for Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of the Code of Federal Regulations.

DISCUSSION
The barriers to implementation of e-prescribing of controlled substances have been significant, but due to ongoing AMA advocacy a number of impediments have been addressed at the state and federal levels. The current challenge to streamlining adoption rests primarily with antiquated and burdensome DEA restrictions that the AMA continues to challenge. In addition, federal Medicaid regulations also drive state law impediments to electronic prescribing.

State Laws
All states allow electronic prescribing of controlled substances, and three go so far as to actively mandate it. New York mandated use of electronic prescribing of all prescriptions as of March 27, 2016. Maine’s mandate for e-prescribing of controlled substances went into effect July 1, 2017.
Virginia’s EPCS mandate, which does not go into effect until July 1, 2020, is limited to drugs containing opiates. Both New York and Virginia allow prescribers to apply for waivers. Also, at the time this report was drafted, several other states are considering legislation to mandate EPCS. However, in order for prescriptions to be reimbursable by Medicaid, a physician must certify in his or her own handwriting that a specific brand is medically necessary for a particular recipient. The state requirements are mandated by federal regulations. The state Medicaid programs must decide what certification form and procedure are used. Federal regulations provide that a checkoff box on a form is not acceptable, but a notation like “brand necessary” is allowable. Thus, there are state laws that require specifying “brand necessary,” particularly for Medicaid patients, and must be done in a physician’s handwriting.

Centers for Medicare & Medicaid Services (CMS)

CMS does not currently have a role in regulating EPCS. Beginning in 2009 there was a Medicare e-prescribing incentive program, but 2013 was the final program year for participating and reporting in this program. In addition, the CMS e-prescribing incentive program exempted EPCS, so controlled substance prescriptions were not an issue. CMS does have oversight responsibility for the Medicare Part D prescription drug benefit program, and it requires all Part D plan sponsors to support e-prescribing. Instead of developing its own e-prescribing standards, CMS adopted the standards developed by the National Council for Prescription Drug Programs (NCPDP), most recently the NCPDP Formulary and Benefits 3.0 transaction standards. In addition, CMS does have oversight of the Medicaid program, and as discussed above, federal regulations that require physicians to submit handwritten statements when a substitution is not permitted represent a barrier to electronic prescribing without a legitimate justification, as the information could be efficiently and securely transmitted through electronic prescribing.

U.S. Drug Enforcement Administration

The AMA continues concerted engagement to address barriers to e-prescribing of controlled substances due to overly burdensome DEA regulations. In 2010, the AMA provided comments as part of the DEA’s rulemaking process and raised concerns with a number of regulations and requirements that should be modified to facilitate widespread e-prescribing of controlled substances. More recently, the AMA again met with the DEA and reinforced and expanded on those recommendations that would enhance security (and decrease diversion) while streamlining the administrative burden. The AMA noted that many physicians have reported that a well-designed electronic medication prescription (eRx) system adds value to their practice of medicine and supports better patient care. The AMA stated that improving on the utility of EPCS to match that of current eRx capabilities will benefit physicians and patients alike. The AMA communicated the points below.

Two-factor authentication. While authentication through a combination of personal identification numbers (PINs), passwords, and biometrics increases the security of EPCS, it also contributes to frequent workflow disruptions and increases costs for many physicians. An AMA survey found that primary care physicians write up to 100 prescriptions per day. Other specialists usually write an average of 10 to 25 prescriptions per day. This volume of prescriptions makes compliance with two-factor authentication, particularly as a distinct process from e-prescribing of non-controlled substances onerous and a significant strain on practice workflows. Few health information technology (health IT) vendors currently support EPCS, and those that do often require physicians to purchase add-on modules or pay separate monthly service fees outside those of normal product maintenance. In speaking with many DEA-registered physicians, the AMA has found that many methods and processes health IT vendors utilize for EPCS are not well-aligned with normal eRx
workflows. In most instances, physicians must initiate an entirely new set of computer programs and windows each time they wish to use EPCS. The AMA shared with the DEA that cumbersome workflows and applications that do not take physician needs into account are the primary impediment to physician EPCS uptake and should be squarely addressed by system designers and product implementers. The DEA requirement that biometric devices comply with Federal Information Processing Standards (FIPS) compounds this problem by limiting many user-friendly consumer electronics already found in physicians’ offices from being utilized. The AMA asked that the DEA reexamine the scope of technology that is compliant with EPCS requirements and allow for lower-cost, high-performing biometric devices (e.g., fingerprint readers on laptop computers and mobile phones) to be leveraged in two-factor authentication.

Identity proofing. For individual physicians in private practice, identity proofing (verifying that the authenticated user is who he/she claims to be) must occur by an authorized third party that will, after verifying the physician’s identity, issue the authentication credential to the DEA registrant. The current identity proofing process is complex and must be performed for each location a physician wishes to employ EPCS. The AMA recommended that the DEA allow a physician’s hospital credentialing to be used for his or her EPCS identity proofing instead of requiring a separate process for EPCS. The AMA also suggested that DEA engage with initiatives like the Administration’s National Strategy for Trusted Identities in Cyberspace federated identity management program. Current regulations further require that, once the authentication credential has been issued to the DEA-registered physician, logical access controls must be established to verify that the authenticated user has the authority to perform the requested operation. The AMA communicated to the DEA that there is not a rational basis for requiring two-person access controls for EPCS on top of the other requirements and the AMA recommended that it be eliminated.

Audit requirements. The current DEA regulation provides that any person designated to set logical access controls is responsible for determining whether any identified auditable event represents a security incident that compromised or could have compromised the integrity of the prescription records (e.g., an unauthorized person attempting to sign or alter a prescription would be an auditable event; a pharmacist annotating a record to indicate a change to a generic version of a drug would not be). EPCS applications must run the internal audit function daily to identify any auditable events. When one occurs, the application must generate a readable report for the physician or pharmacist. If a physician or pharmacy determines that there is a potential security problem, it must be reported to the DEA within one business day. The AMA shared with the DEA that the one day requirement for physicians to report a compromised authentication protocol is impractical. Longer reporting timeframes, such as those required for HIPAA breaches, can be used as a precedent for revising this requirement. Additionally, the AMA urged the DEA to consider how health IT vendors may better support the review of audit logs and reduce the need for manual review by physicians.

PDMP. PDMPs have the promise to be an essential tool for physicians to help prevent drug misuse, diversion, and overdose. Currently, most PDMPs have limited or no ability to connect with and share information to third-party applications. The AMA urged the DEA to work with its state and federal partners to encourage the interoperability of PDMP databases, electronic health records, and other health IT products to improve the integration of data on controlled substance use into practice workflows and physicians’ clinical decision-making.

DEA fees and EPCS compliance costs. The AMA pointed out to the DEA that physicians often face excessive costs for complying with EPCS requirements. Many physicians—especially those in small and solo practices—face high fees associated with the extensive technical, security, and other standard requirements (e.g., costs for identity proofing, access control training and the setting of
access controls, hardware, software or application purchase and maintenance, reprogramming, and
audit requirements), along with workflow adjustments needed for EPCS. In addition to the costs of
compliance with EPCS, there are also monthly fees levied by health IT vendors. These fees and
costs pose a significant barrier to EPCS adoption. As DEA registration fees ($731 for three years)
are set to cover the costs of its diversion control program and a major purpose of EPCS is to lower
the risk of drug diversion, the AMA urged the DEA to consider reducing registration fees for those
who employ EPCS.

Clearer guidance. The AMA also shared with the DEA that the current regulations are difficult to
comprehend. The AMA strongly urged the DEA to provide clarity and simplified guidance,
including examples, to help physicians understand exactly what is required of them for EPCS
compliance.

Recent Efforts

The AMA met with Surescripts, a health information network that connects health information
technology (electronic health records, pharmacy systems) used by pharmacies, health care
providers, and benefit managers, because Surescripts is often cited as one of the best examples of
interoperability in the health care industry today. One of the meetings focused on EPCS where
AMA staff reviewed the recommendations submitted to the DEA outlined above. Surescripts noted
general agreement with the AMA concerns and AMA suggested solutions. More recently, on May
18, 2017, the AMA submitted comments to the President’s Commission on Combating Drug
Addiction and the Opioid Crisis. The AMA again reiterated that the DEA requirements for
biometric devices limit user-friendly consumer electronics already found in physicians’ offices,
such as fingerprint readers on laptop computers and mobile phones, from being utilized for two-
factor authentication in EPCS. The AMA noted that this and other rules contribute to cumbersome
workflows and applications that do not take physician needs into account, which are an impediment
to physician EPCS uptake. Furthermore, the AMA stated that encouraging EPCS uptake and
interoperability of PDMP databases and electronic health records would improve the integration of
controlled substance use data into practice workflows and clinical decision-making. AMA staff are
preparing to follow-up directly with DEA.

CONCLUSION

During consideration of Resolution 216 there was consensus that it raised legitimate concerns. On
the other hand, there was testimony in the reference committee urging reaffirmation of existing
policy. In addition, during the HOD’s consideration of the Resolution and reference committee
recommendation, a number of delegates noted that current AMA policy, while largely still relevant,
should be updated.

RECOMMENDATIONS

The Board of Trustees recommends that the following policies be amended and the remainder of
the report be filed.

Guidelines,”
Our American Medical Association will continue to advocate before relevant federal and state
agencies and legislative bodies for the elimination of address with the Centers for Medicare &
Medicaid Services and the Drug Enforcement Administration the contradictory, cumbersome,
confusing, and burdensome requirements guidance, issued respectively by those two federal
agencies, relating to electronic transmission of physicians’ controlled substance prescriptions
to pharmacies—commonly referred to as “e-prescribing”—Electronic Prescribing for
Controlled Substances (EPCS). This includes for Schedules II, III, IV and V drugs, as those
current guidelines add rather than reduce administrative paperwork and defeat the purpose of
electronic handling of prescriptions (Modify Current HOD Policy).

2. That current AMA Policy D-120.958, “Federal Roadblocks to E-Prescribing,”
Our AMA will initiate discussions work with the Centers for Medicare and Medicaid Services
and states to remove or reduce barriers to electronic prescribing of both controlled substances
and non-scheduled prescription drugs, including removal of the Medicaid requirement in all
states that continue to mandate that physicians write, in their own hand, “brand medically
necessary” or the equivalent on a paper prescription form.

2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow
electronic prescribing of Schedule II prescription drugs.

3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-
adoption of eE-prescribing.

3. Our AMA will work with the largest and nearly exclusive national electronic pharmacy
network, all related state pharmacy regulators, and with federal and private entities to ensure
universal acceptance by pharmacies of electronically transmitted prescriptions.

4. Our AMA will advocate for appropriate financial and other incentives to physicians to
facilitate electronic prescribing adoption.

5. Our AMA will: (A) investigate work to substantially reduce regulatory burdens so that
physicians may successfully submit electronic prescriptions for controlled substances; and (B)
work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g.,
the Physician Quality Reporting System, meaningful use, and e-pPrescribing) the requirement
to electronically prescribe controlled substances, until such time that the necessary protocols
are in place for electronic prescribing software vendors and pharmacy systems to comply.

6. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and
software vendors to expand the ability to electronically prescribe all medications.

7. Our AMA will petition work with the Centers for Medicare & Medicaid Services and the
federal government to have all pharmacies, including government pharmacies, accept e-
prescriptions for prescription drugs or to temporarily halt the e-prescribing requirements of
meaningful use until this is accomplished (Modify Current HOD Policy).

3. That current AMA Policy H-120.957, “Prescription of Schedule II Medications by Fax and
Electronic Data Transmission,”
Our AMA: (1) encourages the Drug Enforcement Administration to rewrite Section 1306 of
Title 21 of the Code of Federal Regulations to support two factor authentication that is easier to
implement than the current DEA and EPCS security requirements accommodate encrypted
electronic prescriptions for Schedule II controlled substances, as long as sufficient security
measures are in place to ensure the confidentiality and integrity of the information. (2) Our
AMA supports the concept that public key infrastructure (PKI) systems or other signature
technologies designed to accommodate electronic using prescriptions should be readily
adaptable to current computer systems, and should satisfy the criteria of privacy and
confidentiality, authentication, incorruptibility, and. (23) Because sufficient concerns exist
about privacy and confidentiality, authenticity, and other security measures, the AMA does not
support the use of "hard copy" facsimile transmissions as the original written prescription for
Schedule II controlled substances, except as currently allowed in Section 1306 of Title 21 of
the Code of Federal Regulations (Modify Current HOD Policy).

Fiscal note: Less than $500.
Whereas, In the wake of the AIDS epidemic in the 1980s, the U.S. Food and Drug Administration (FDA) created pathways by which specialty drugs could be approved based on less rigorous data, including a “fast track” pathway for drugs that treat life-threatening or severely debilitating conditions, which allows approval on the basis of uncontrolled Phase II trials, and an “accelerated approval” pathway which lowers evidentiary requirements for drugs for serious or life-threatening conditions if the drug provides a meaningful therapeutic benefit not provided by existing treatment, both of which have reduced the time to approval for designated specialty drugs; and

Whereas, In the period of 2000-2013, 82 drugs were approved under the fast-track designation, representing 22% of all drugs including biologics approved by the FDA during that time period, yet only 49 of the 82 were specialty drugs; and

Whereas, In the same period of 2000-2013, 37 new drugs were granted accelerated approval (10% of all drugs including biologics), of which 26 were specialty drugs; and

Whereas, In 2012 the United States Congress created another expedited pathway for so-called “breakthrough therapies” which could be designated by FDA based on early clinical signs of promise, expected to be used only a few times a year but which received over 100 applications for designation in 2013; and

Whereas, These expedited pathways usually allow for drug approval some time during Phase III which lasts approximately from 1-4 years, and the standard drug approval process has a median approval time of 10.1 months from receipt of application, thereby resulting in expedited pathway approval approximately 5 years before said drug would be approved via the standard pathway; and

Whereas, These expedited approval pathways pose challenges to the evidence-based prescribing of approved drugs, since designations provide strong signals to the public about the clinical importance of the drugs entering these pathways and drugs that are approved after a shortened premarket period or drugs approved based on invalidated surrogate endpoints may later be found to have greater risks, or less certain benefits, than was initially believed to be the case; and

Whereas, Approval of an expensive new specialty drug based only on preliminary data suggesting that it might improve patient outcomes and resultant use by clinicians may divert resources away from other health care interventions that have been confirmed to be effective or that present greater value; and
Whereas, These expedited pathways require post-approval testing to confirm the drugs’ predicted benefit-risk profiles, yet one 2011 review of forty-seven oncology drugs approved through the “accelerated approval” pathway in the period 1992–2010 found that trials for eighteen had not been completed at the time of the review; and

Whereas, FDA has limited power to ensure that mandatory post-approval trials for drugs approved via these pathways be conducted in a timely and rigorous manner, being able to impose civil fines of up to $10 million, which is but a fraction of the enormous profit specialty drugs can generate; and

Whereas, Removing a drug from the market often draws criticism from physicians and patient-advocacy groups, even for drugs which lack data supporting their effectiveness or safety; and

Whereas, A system by which approval for drugs brought forward under these expedited pathways would be designated as temporary and have a set expiration date, with more permanent FDA approval given under the condition of further evidence supporting safety and efficacy, would shift the burden to the manufacturer to show that its drug should remain on the market; and

Whereas, Legislative action would be required to further modify the FDA expedited pathway processes; and

Whereas, Robert M. Califf, M.D., former FDA Commissioner noted that with the passage of the 21st Century Cures Act “great progress has been made towards our shared goal of advancing regulatory science so that we can continue to speed the discovery, development, and delivery of medical products to prevent and cure disease and improve health while sustaining the evidence framework that enables assurance to the public of the safety and effectiveness of medical products;” therefore be it

RESOLVED, That our American Medical Association work with U.S. Food and Drug Administration (FDA) and other interested stakeholders to design and implement via legislative action (including ensuring appropriate FDA staffing) a process by which drugs which obtain FDA approval via the Fast Track, Accelerated Approval, or Breakthrough Therapy pathways be granted FDA approval on a temporary basis not to exceed 5 years, pending further evidence of safety and efficacy that is at the level set for the standard drug approval process (Directive to Take Action); and be it further

RESOLVED, That our AMA work with the FDA and other interested stakeholders in improving the process by which drugs are selected for the expedited pathway to improve the prevalence of these drugs that are classified as “specialty drugs.” (Directive to Take Action)

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

Received: 09/06/17

RELEVANT AMA POLICY

FDA H-100.992
(1) Our AMA reaffirms its support for the principles that: (a) an FDA decision to approve a new drug, to withdraw a drug's approval, or to change the indications for use of a drug must be based on sound scientific and medical evidence derived from controlled trials and/or postmarket incident reports as provided by statute; (b) this evidence should be evaluated by the FDA, in consultation with its Advisory Committees and expert extramural advisory bodies; and (c) any risk/benefit analysis or relative safety or efficacy judgments should not be grounds for limiting access to or indications for use of a drug unless the weight of the evidence from clinical trials and postmarket reports shows that the drug is unsafe and/or ineffective for its labeled indications.
(2) The AMA believes that social and economic concerns and disputes per se should not be permitted to play a significant part in the FDA's decision-making process in the course of FDA devising either general or product specific drug regulation.
(3) It is the position of our AMA that the Food and Drug Administration should not permit political considerations or conflicts of interest to overrule scientific evidence in making policy decisions; and our AMA urges the current administration and all future administrations to consider our best and brightest scientists for positions on advisory committees and councils regardless of their political affiliation and voting history. (Res. 119, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmation, A-06; Appended: Sub. Res. 509, A-06; Reaffirmation, I-07; Reaffirmation, I-09; Reaffirmation, I-10)

Addressing the Exploitation of Restricted Distribution Systems by Pharmaceutical Manufacturers H-100.950
1. Our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek Food and Drug Administration and Federal Trade Commission approval before establishing a restricted distribution system.
2. Our AMA supports requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays.
3. Our AMA will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs. (Res. 809, I-16)

Food and Drug Administration H-100.980
(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate. (Sub. Res. 548, A-92; BOT Rep. 32, A-95; BOT Rep. 32, A-95; BOT Rep. 18, A-96; Reaffirmed: BOT Rep. 7, I-01; Reaffirmation I-07; Reaffirmed: Sub. Res. 504, A-10; Reaffirmation A-15; Reaffirmed: CMS Rep. 06, I-16)
Whereas, The Violence Against Women Reauthorization Act of 2013 requires state, tribal and local governments to offer medical forensic examinations to victims of sexual assault despite whether the victim participates in the criminal justice system;¹,² and

Whereas, The legal rights of a crime victim are not protected nor elucidated for sexual assault survivors in some states;³,⁴,⁵,⁶,⁷ and

Whereas, Sexual assault evidence collection kit storage policies vary across jurisdictions, resulting in (1) some kits being discarded in as little as 30 days or kits being discarded before the state-specific statute of limitations, (2) some survivors being charged for their own evidence collection kit or associated treatments, and (3) some sexual assault survivors are given no information about the testing or results of their kits;³,⁴,⁸,⁹ and

Whereas, Requiring sexual assault survivors to repeatedly request extensions for the preservation of their kits, especially if they remain undecided about pursuing legal action, places an undue burden on the survivor with consequences to their mental health and recovery;⁴,⁸ and

Whereas, The federal Survivors’ Bill of Rights Act of 2016 (SBRA) establishes that a survivor of sexual assault has the right to receive a medical forensic examination at no cost, that the evidence collection kit be preserved, without charge, for the duration of the statute of limitations or 20 years, that the survivor be informed of the results of the kit, that the survivor be notified of plans to destroy the kit, that the survivor be granted further preservation of the kit if requested, and that the survivor be informed of these rights;¹⁰,¹¹ and

Whereas, The federal government is limited in its ability to change law enforcement practices at the state level and since the provisions of SBRA involve elements of law enforcement, adopting the federal standards set by SBRA can only be accomplished by individual state legislation;¹² and

Whereas, Five states (MA, WA, VA, OR, MD) have passed legislation similar to the Survivors’ Bill of Rights Act of 2016, five additional states (VT, CA, MN, OK, WV) have introduced similar legislation, and twenty one states have ongoing advocacy efforts to consider similar legislation; and

Whereas, SBRA instructs the Attorney General and the Secretary of Health and Human Services to establish a joint working group, including the medical provider community, to develop, coordinate, disseminate and encourage implementation of best practices regarding the care of sexual assault survivors and the preservation of evidence among hospital administrators, physicians, forensic examiners, medical community leaders, and medical associations; and

Whereas, Pursuant to AMA policy H-80.998, the AMA supports the function and efficacy of rape victim services and AMA policy H-80.999, the AMA supports the preparation and dissemination of information intended to maintain and improve the skills needed by all practicing physicians involved in providing care to rape victims; and

Whereas, Existing AMA policy specifically addressing information for physicians on the medical-legal rights of sexual assault survivors would improve the care physicians can provide to victims of sexual assault who are their patients; and

Whereas, Collaboration between medical and legal communities on the rights of sexual assault survivors would improve health outcomes for these victims; therefore be it

RESOLVED, That our American Medical Association advocate for the legal protection of sexual assault survivors’ rights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (1) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (2) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (3) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (4) be informed of these rights and the policies governing the sexual assault evidence kit (New HOD Policy); and be it further

RESOLVED, That our AMA collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor’s Bill of Rights Act of 2016. (Directive to Take Action)

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

Received: 09/12/17

RELEVANT AMA POLICY

Whereas, In 2017 physicians are increasingly required to send prescriptions electronically to pharmacies, also known as e-prescribing; and

Whereas, Physicians are also responsible for an accurate update in the Electronic Health Record (EHR) for their patient’s active current medications; and

Whereas, Many patients cannot recall their medications, prescribed dosage, route of administration, or how often they should take them; and

Whereas, The technology exists to have bidirectional communication between EHR software and pharmacies to keep patient medications in the Electronic Health Record accurate and current; therefore be it

RESOLVED, That our American Medical Association engage the American Pharmacy Association, and any other relevant stakeholders, to encourage both Electronic Health Record (EHR) and pharmacy software vendors to have bidirectional communication for an accurate and current medication list in the patient’s EHR. (New HOD Policy)

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

Received: 09/18/17
whereas, for the 2017 quality payment program (qpp) physicians have the option to use electronic health record (ehr) technology certified to the 2014 or 2015 edition, or a combination of 2014 or 2015 editions; and

whereas, starting in 2018, physicians are required to use only 2015 certified electronic health record technology (cehrt); and

whereas, very few vendor products meet the 2015 certification criteria required for approval by the office of the national coordinator for health information technology (onc) health it certification program; and

whereas, mandating use of ehr technology certified to the 2015 edition cehrt by 2018 may unfairly subject physicians to financial penalties under the qpp or force them to file for hardship exceptions due to unavailable vendor products; therefore be it

RESOLVED, that our american medical association petition the centers for medicare and medicaid services (cms) to require electronic health record (ehr) vendors, offering technology for physician use, meet all current certification requirements as approved by the onc’s health it certification program (directive to take action); and be it further

RESOLVED, that our ama advocate that ehr vendors, not physicians, be financially penalized for ehr technology not meeting current standards. (new hod policy)

fiscal note: modest - between $1,000 - $5,000.

received: 09/18/17
Whereas, The multitude and ever-changing requirements of health plans and pharmacy benefit managers creates an enormous burden on physicians caring for their patients; and

Whereas, There are numerous similar medications for a prescribed class of pharmaceutical agent and different health plans mandate use of one or two due to contractual obligations and cost. In addition, these approved medications can change frequently within a single health plan; and

Whereas, Technology exists today to solve this problem; therefore be it

RESOLVED, That our American Medical Association advocate that health plans, pharmacies, and EHR vendors integrate their technology programs so that physicians have current and real time access to covered medications for patients within a specific health plan (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that health plans make patient cost information readily available via this technology so that physicians and their patients may work together to choose the most cost-effective medically appropriate medication for patient care. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(I-17)

Introduced by: Medical Student Section

Subject: Defending Federal Child Nutrition Programs

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

Whereas, The United States Department of Agriculture’s (USDA) child nutrition programs which include resources such as the National School Lunch Program (NSLP) and the School Breakfast Program (SBP) serve as vital lifelines in preserving and improving the general health of children in the United States; with 58% of school-age children in the US utilizing NSLP and/or SBP on a given school day; and

Whereas, The Healthy, Hunger-Free Kids Act (HHFKA) of 2010 updated nutrition standards for federal child nutrition programs and enabled the USDA to align school meal program resources with its Dietary Guidelines for Americans (DGA); and

Whereas, In 2012, the USDA issued updated nutritional guidelines for child nutrition programs which further compelled schools to add more fruits, vegetables, and legumes while reducing fat, sodium, and caloric content in provided foods; and

Whereas, In 2015, more than 13.1 million children were food insecure and thereby at increased risk for deficiencies in one or more nutrients, placing them at significantly higher risk for illness altered cognition, and decreased mental performance; and

Whereas, Early exposure to nutrition education and access to fruits and vegetables play a significant role on the shaping of good longitudinal dietary habits and mitigate the risk of developing early onset obesity and diseases associated with obesity such as diabetes and hyperlipidemia; and

Whereas, Several recent studies indicate the USDA’s updated nutritional standards positively
impact student fruit and vegetable consumption as well as food insecurity and its associated
health and nutritional complications;\textsuperscript{9,12,13,14,15} and

Whereas, The US Senate Committee on Agriculture, Nutrition, and Forestry successfully
persuaded the USDA in 2013 to grant flexibility on implementation of its 2012 school meal
nutritional standards and under new administration in 2016, the USDA has granted even greater
flexibility in implementation of these standards;\textsuperscript{16,17} and

Whereas, Our AMA currently has no policy efforts to reduce or eliminate federal child nutrition
programs (AMA Policies H-150.944 and H-150.962); and

RESOLVED, That our American Medical Association oppose legislation that reduces or
eliminates access to federal child nutrition programs (New HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-150.962, “Quality of School Lunch Program.”
(Reaffirm HOD Policy)

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

Received: 09/20/17

RELEVANT AMA POLICY

Quality of School Lunch Program H-150.962
The AMA recommends to the National School Lunch Program that school meals be congruent with
current U.S. Department of Agriculture/Department of HHS Dietary Guidelines. (Sub. Res. 507, A-93

See also:
Support for Uniform, Evidence-Based Nutritional Rating System H-150.936;
Rating System for Processed Foods H-150.942
Excess Sodium in the Diet H-150.997
Promotion of Healthy Lifestyles I: Reducing the Population Burden of Cardiovascular Disease by
Reducing Sodium Intake H-150.929
American's Health H-440.859
Addressing Obesity D-440.954
Combating Obesity and Health Disparities H-150.944
Obesity as a Major Public Health Problem H-150.953
Prevention of Obesity Through Instruction in Public Schools H-170.961
Sustainable Food D-150.978
Culturally Responsive Dietary and Nutritional Guidelines D-440.978
Recognizing and Taking Action in Response to the Obesity Crisis D-440.980

\textsuperscript{14} Cohen JFW, Richardson S, Parker E, Catalano PJ, Rimm EB. Impact of the new U.S. Department of Agriculture school meal
\textsuperscript{15} Terry-McElrath YM, O'Malley PM, Johnston LD. Foods and beverages offered in US public secondary schools through the
\textsuperscript{16} Roberts P. Senator Roberts: USDA Grants Flexibility on School Meals; Waste and Cost Remain a Concern. United States Senate
Committee on Agriculture, Nutrition, and Forestry.
\textsuperscript{17} “Ag Secretary Perdue Moves to Make School Meals Great Again.” USDA, United States Department of Agriculture Press, 1 May
WHEREAS, There is a surplus of unused medications in the US including long-term care facilities discarding $2 billion worth of medications already paid for by federal and state governments annually, leaving a potential $700 million to be saved by reusing these discarded medications;\(^1\,^2\) while hospital pharmacies and other health care providers spend approximately $1 billion on unused medications annually;\(^3\) and

WHEREAS, Current Drug Enforcement Administration (DEA) standards of drug disposal include drug take-back programs, mail-back programs, and collection receptacles, with collected prescription drugs being destroyed by incineration;\(^4\,^5\) and

WHEREAS, 38 states have passed pharmaceutical donation and reuse legislation for non-controlled substances, and 20 states have created operational pharmaceutical donation and reuse programs dedicated to collecting unused medications to redistribute to patients for little or no cost;\(^6\,^7\) and

WHEREAS, The determination of recipients of legally redistributed prescription medications are determined by state regulations and the Department of Human Resources;\(^6\) and

WHEREAS, The safe return and reuse of prescription medications allows for increased access to prescription medications, as demonstrated by Oklahoma’s Drug Recycling Program, which has redistributed over 200,000 prescriptions worth $20 million to those in need since 2004;\(^8\) and

WHEREAS, A common obstacle to establishing a pharmaceutical donation and reuse program is the absence of funding, as depicted by Texas’s Drug Donation Pilot Program;\(^9\) and

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Whereas, In a time of persistently rising prescription drug costs, establishing pharmaceutical donation and reuse programs not only allows for the proper recycling of these drugs, but also increased access to prescription drugs by the 35 million Americans who are unable to afford their medications; and

Whereas, The “AMA supports access to safe, convenient, and environmentally sound medication return for unwanted prescription medications” by working “with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations” (AMA Policies H-135.925, H-135.936); and

Whereas, The AMA Opioid Task Force encourages safe storage and disposal of opioids and all medications; therefore be it

RESOLVED, That our American Medical Association work with appropriate stakeholders to draft and promote model legislation aimed at developing better funding for drug donation programs on the state level provided these programs follow the quality assurance guidelines set by existing AMA Policy H-280.959. (Directive to Take Action)

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

Received: 09/20/17

RELEVANT AMA POLICY

Recycling of Nursing Home Drugs H-280.959

Our AMA supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) and to offer substantial savings to the health care system, provided the following conditions are satisfied: (1) The returned medications are not controlled substances. (2) The medications are dispensed in tamper-evident packaging and returned with packaging intact (e.g., unit dose, unused injectable vials and ampules). (3) In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity. (4) Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy. (5) A system is in place to track re-stocking and reuse to allow medications to be recalled if required. (6) A mechanism (reasonable for both the payer and the dispensing LTC pharmacy) is in place for billing only the number of doses used or crediting the number of doses returned, regardless of payer source.


See also:
Medications Return Program H-135.925
Contamination of Drinking Water by Pharmaceuticals and Personal Care Products D-135.993
Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs H-135.936

Whereas, “Police officers are more risk averse and cautious about their actions when wearing on-officer video technology,” with studies showing a 53% decrease in response-to-resistance incidents and a 59% decrease in use-of-force incidents;¹,²,³ and

Whereas, Police officers using body-worn cameras are about half as likely to use force compared to officers who didn’t have body-worn cameras;⁴ and

Whereas, During the course of a study, police officers using body-worn cameras experienced a 47.7% decline in the number of complaints received, compared to a 7.4% decline in the number of complaints received by a control group of officers not wearing body-cameras;⁵ and

Whereas, After using body-worn cameras, most police officers agree that use of a body-worn camera “provides a more accurate account of an incident” and “improves the quality of evidence”;⁶ and

Whereas, Our AMA has affirmed that “physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health” (AMA Policy H-515.955); and

Whereas, Existing AMA policy states that our AMA will “facilitate the development and implementation of a comprehensive, long-range, coordinated strategy to address issues and concerns affecting minorities, including minority health,” including the “development, coordination, and strengthening of AMA resources devoted to minority health issues” (H-350.971); therefore be it

RESOLVED, That our American Medical Association advocate for legislative, administrative, or regulatory measures to expand funding for (1) the purchase of body-worn cameras and (2) training and technical assistance required to implement body-worn camera programs. (New HOD Policy)

² Wesley G. Jennings, Matthew D. Lynch, Lorie A. Fridell, Evaluating the impact of police officer body-worn cameras (BWCs) on response-to-resistance and serious external complaints: Evidence from the Orlando police department (OPD) experience utilizing a randomized controlled experiment, Journal of Criminal Justice, 2015, Pages 480-486, ISSN 0047-2352
Fiscal Note: Minimal - less than $1,000.

Received: 09/20/17

RELEVANT AMA POLICY

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955
Initiatives Regarding Minorities H-350.971
Use of Conducted Electrical Devices by Law Enforcement Agencies H-145.977
Guns in Hospitals H-215.977
Whereas, EMR mandates do not increase relative value unit (RVU) values; and

Whereas, There are unfunded mandates for quality; and

Whereas, Funding was approved as appropriate before sequester; therefore be it

RESOLVED, That our American Medical Association advocate to remove the sequester provision for Part B Medicare reimbursement. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Whereas, The merit-based incentive payment system (MIPS) is a very complicated, burdensome payment system developed by the Centers for Medicare & Medicaid Services; and

Whereas, Small practices do not have the time and financing to understand and implement this program; and

Whereas, MIPS will essentially force small, independent practices out of business; therefore be it

RESOLVED, That our American Medical Association advocate for a policy that exempts self-employed small practices, defined as solo practitioners up to five physician providers, from the burdensome regulation of the merit-based incentive payment system (MIPS). (Directive to Take Action)

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

Received: 09/26/17
WHEREAS, States have some ability to approve and regulate methadone clinics. In Indiana, the federal government has ultimate control of methadone clinics location, size and operations; and

WHEREAS, Some federal methadone clinic policies contrast with the policies desired by the state. The best example of this is the rule that does not require participants of methadone clinics to be reported in the state controlled substances database. Therefore, some individuals have gone to two methadone clinics at the same time. They would take one clinic’s medication and sell the other’s take home medication. Another example relates to past issues with drug rehab and counseling at Indiana methadone clinics. In some cases, it was quite minimal with majority of the visits dedicated to the transaction of selling an opioid and collecting payment. Additionally, larger clinics don’t necessarily offer benefit to patients with size increasing the possibility of logistical problems and possibly making the visit process less personable and less therapeutic. Clark County Indiana is home to the largest methadone clinic in the country with over 1,600 active clients; and

WHEREAS, State control of the methadone clinics would allow local decisions about size, location, and operational rules and regulations; and

WHEREAS, Many recommendations have been made by the states over the years related to improving methadone clinic operations, and yet many of these have not been adopted by federal regulators; and

WHEREAS, A segment of the opioid-addicted population will never be able to be opioid abstinent. It is therefore acknowledged that methadone clinics provide a valuable service to opioid-addicted individuals; therefore be it

RESOLVED, That our American Medical Association support complete state control of all aspects of methadone clinic approval and operations; and, if deemed necessary, this control could be granted on a state by state basis. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Whereas, The lack of transparency of prices for medical services and drugs at point of service is a burden for both physicians and patients; and

Whereas, Prices for medical services vary greatly across the country\(^1\); and

Whereas, Patients have the right to discuss with their physicians the benefits, risks, and costs of all treatment options; and

Whereas, Lack of transparency prevents physician and patient from discussing expected costs for services and treatments and can potentially foster a sense of distrust between the patient and physician; and

Whereas, In specific states insurers can have gag clauses in contracts preventing disclosure of pricing information and claims data; and

Whereas, These arrangements affect hospital-based and other employed physician’s ability to develop rational prices, price transparency, appropriately discount, and use customary price discrimination for services; and

Whereas, There is the opportunity for the AMA to take the lead on state level bills targeting this issue; therefore be it

RESOLVED, That our American Medical Association work with states and state medical societies to reduce health insurance contract provisions or gag clauses that restrict disclosure of pricing information to patients (Directive to Take Action); and be it further

RESOLVED, That our AMA work with states and state medical societies to ensure that health insurance contracts do not prohibit the application of discounts to uninsured or under-insured patients if such discounts are compliant with federal anti-kickback statutes (Directive to Take Action); and be it further

RESOLVED, That our AMA support access to real-time prescription drug pricing and cost transparency at the point of prescribing. (New HOD Policy)

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

Received: 09/29/17

RELEVANT AMA POLICY

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16

Appropriate Hospital Charges H-155.958
Our AMA encourages hospitals to adopt, implement, monitor and publicize policies on patient discounts, charity care, and fair billing and collection practices, and make access to those programs readily available to eligible patients.
Citation: (CMS Rep. 4, A-09)

Physicians’ Freedom to Establish Their Fees H-380.994
Our AMA (1) affirms that it is a basic right and privilege of each physician to set fees for service that are reasonable and appropriate, while always remaining sensitive to the varying resources of patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner; (2) supports the concept that health insurance should be treated like any other insurance (i.e., a contract between a patient and a third party for indemnification for expense or loss incurred by virtue of obtaining medical or other health care services); and (3) believes that the contract for care and payment is between the physician and patient.
Citation: (BOT Rep. JJ, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 704 and Reaffirmation A-01; Reaffirmation A-09)
Whereas, Our AMA continues to advocate that physicians are best qualified by their education and training to lead the health care team; and

Whereas, In 2015, the National Council of the State Boards of Nursing (NCSBN) approved state model legislative language entitled the “APRN Compact,” which would create multistate licensure for APRNs (Advanced Practice Registered Nurses); and

Whereas, The APRN Compact would authorize APRNs with this multistate license to practice in other party states without going through state-by-state licensing; and

Whereas, The APRN Compact eliminates physician involvement requirements for APRNs practicing in a state under a multistate license through Article III, Section (h), which provides: “An APRN issued a multistate license is authorized to assume responsibility and accountability for patient care independent of a supervisory or collaborative relationship with a physician. This authority may be exercised in the home state and in any remote state in which the APRN exercises a multistate licensure privilege.”; and

Whereas, The APRN Compact exclusively references the title “APRN” without defining the term allowing then a state that has granted the APRN title the Compact to authorize practice without physician involvement under a multistate license, regardless existing state law; and

Whereas, The APRN Compact requires only ten states to enact the Compact into law before it goes into effect. Two states (Idaho and Wyoming) passed this legislation into law in 2016, and North Dakota passed it into law in 2017; and

Whereas, The APRN Compact establishes an “Interstate Commission” that will take many licensing decisions away from state legislatures and state boards of nursing, creating rulemaking that is legally binding in all party states, including scope of practice and population foci; therefore be it...
RESOLVED, That our American Medical Association convene an in-person meeting of relevant stakeholders to initiate a national strategy to address the APRN (Advanced Practice Registered Nurses) Compact. (Directive to Take Action)

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

Received: 09/29/17

REFERENCES

RELEVANT AMA POLICY

Support for Physician Led, Team Based Care D-35.985

Our AMA:
2. Will identify and review available data to analyze the effects on patients’ access to care in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services) to determine whether there has been any increased access to care in those states.
3. Will identify and review available data to analyze the type and complexity of care provided by all non-physician providers, including CRNAs in the opt-out states (states whose governor has opted out of the federal Medicare physician supervision requirements for anesthesia services), compared to the type and complexity of care provided by physicians and/or the anesthesia care team.
4. Will advocate to policymakers, insurers and other groups, as appropriate, that they should consider the available data to best determine how non-physicians can serve as a complement to address the nation’s primary care workforce needs.
5. Will continue to recognize non-physician providers as valuable components of the physician-led health care team.
6. Will continue to advocate that physicians are best qualified by their education and training to lead the health care team.
7. Will call upon the Robert Wood Johnson Foundation to publicly announce that the report entitled, "Common Ground: An Agreement between Nurse and Physician Leaders on Interprofessional Collaboration for the Future of Patient Care" was premature; was not released officially; was not signed; and was not adopted by the participants.

Citation: BOT Rep. 9, I-11; Reaffirmed: CMS Rep. 1, A-12; Reaffirmed: CMS Rep. 07, A-17
Whereas, Studies have shown that direct costs to living organ donors average approximately $5,000.00, which is greater than one month’s wage for 76 percent of donors; and

Whereas, Between 25 to 30 percent of donors do not have sufficient medical leave and/or vacation time to accommodate their recovery; and

Whereas, Approximately 30 percent of living organ donors are persons of ethnic minorities who have been shown to be at greater risk of financial impacts both pre- and post-donation; and

Whereas, Financial burdens for living kidney donors have been shown to increase risk of depression and lower satisfaction of life scores after surgery; and

Whereas, 83 percent of living kidney donors surveyed in Canada reported an inability to perform household tasks after the surgery for an average of 33 days; and

Whereas, On average, living kidney donors report 252 hours of lost work due to donation; and

Whereas, It takes four to six weeks for a donor to make a full recovery, and during this time it is recommended they rest as much as possible; and

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Accessed December 1, 2016.
4 Purnell TST. Advances in chronic kidney disease: Understanding and overcoming barriers to living kidney donation among racial and ethnic minorities in the United States. WB Saunders Company; 07/2012;19:244.
Whereas, Federal law grants federal employees seven days paid leave for bone marrow
donation and 30 days for organ donation in addition to annual and sick leave\textsuperscript{10}; and

Whereas, The Living Donor Protection Act of 2016 (S.2584) would prevent the discrimination of
living organ donors in conferring insurance and rectify the Family and Medical Leave Act of
1993 to “include living organ donation as a serious health issue that entitles a covered
employee to leave…”\textsuperscript{11}, and

Whereas, Laws in 31 states allow state employees some increment of paid leave for living
organ donation; laws in 20 states offer tax deductions to donors and in some cases private
employers; and, laws in eight states mandate paid leave from private employers\textsuperscript{12,13}; therefore
be it

RESOLVED, That our American Medical Association amend Policy, H-370.965, “Removing
Financial Barriers to Living Organ Donation,” by addition and deletion as follows:

Our AMA supports federal and state laws that remove financial barriers to living organ
donation, such as: (1) provisions for expenses involved in the donation incurred by the
organ donor, (2) providing access to health care coverage for any medical expense
related to the donation, (3) prohibiting employment discrimination on the basis of living
donor status, and (4) prohibiting the use of living donor status as the sole basis for
denying health and life insurance coverage, and (5) provisions to encourage paid leave
for organ donation (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA support legislation expanding paid leave for organ donation. (New
HOD Policy)

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

Received: 09/29/17

RELEVANT AMA POLICY:

Removing Financial Barriers to Living Organ Donation H-370.965
Our AMA supports federal and state laws that remove financial barriers to living organ donation,
such as: (1) provisions for expenses involved in the donation incurred by the organ donor, (2)
providing access to health care coverage for any medical expense related to the donation, (3)
prohibiting employment discrimination on the basis of living donor status, and (4) prohibiting the
use of living donor status as the sole basis for denying health and life insurance coverage.
Citation: (BOT Rep. 15, A-12)

\textsuperscript{10} U.S. Office of Personnel Management. (2016) “Bone Marrow or Organ Donor Leave. 5 U.S.C. 6327” Available at:
Accessed December 1, 2016.

\textsuperscript{11} Living Donor Protection Act of 2016. S.2584. 114th Congress (2015-2016)

\textsuperscript{12} U.S. Department of Health & Human Services. (2010) “State Organ Donor Legislation” Available at:

\textsuperscript{13} National Kidney Foundation. (2016) “Donor Leave Laws and Tax Deductions/Credits for Living Donors” Available at:
Whereas, Medicine is undergoing unprecedented changes; and
Whereas, New care delivery and reimbursement models measure physicians on their population-level performance; and
Whereas, Physicians are best situated to lead the charge as the American health care system transitions into new era of enhanced clinical integration, collaboration, and system sophistication; therefore be it

RESOLVED, That our American Medical Association continue to consider and implement the most strategic and sustainable approaches to collaborate and engage with the US Department of Health and Human Services to: (1) advance and advocate for policies of importance to physicians and patients; (2) promote physician leadership in emerging health care organizational and reimbursement structures; and (3) enhance the opportunity for physician input. (Directive to Take Action)

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

Received: 09/29/17

RELEVANT AMA POLICY

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors’ access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

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

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

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

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
   a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
   b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
   c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
   d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
   e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
   f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

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

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

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

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

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

Citation: Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmation A-12; Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15; Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 712, A-17;

**Increasing Collaboration Between Physicians and the Public to Address Problems in Health Care Delivery H-160.904**

Our American Medical Association will continue to consider and implement the most strategic and sustainable approaches to stay engaged with physician and non-physician stakeholders essential to our endeavor to improve the delivery of quality medical care.

Citation: Res. 612, A-15; Modified: BOT Rep. 18, A-16;
Whereas, The US Food and Drug Administration may be considering new rules regarding the repair of medical tools, equipment, and instruments; and

Whereas, There are indications that some individuals believe that the repair of medical tools, equipment, and instruments by non-factory authorized service personnel increases the risk of failure of the device; and

Whereas, There is no scientific data to show that medical tools, equipment, and instruments that have been repaired or refurbished by non-factory/manufacturer authorized service personnel pose any greater safety risk than those repaired by factory/manufacturer authorized personnel; and

Whereas, There have been suggestions that persons engaged in the repair and/or refurbishment of medical tools, equipment, and instruments should be licensed; and

Whereas, There is no evidence to show that licensing guarantees competency; and

Whereas, Additional rules and regulations regarding the repair and refurbishment of medical tools, equipment, and instruments could increase the cost of health care without offering any benefit to patients; therefore be it

RESOLVED, That our American Medical Association strongly oppose any rules or regulations regarding the repair or refurbishment of medical tools, equipment, and instruments that are not based on objective scientific data. (New HOD Policy)

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

Received: 09/29/17
RELEVANT AMA POLICY

Medical Device Safety and Physician Responsibility H-480.972
The AMA supports: (1) the premise that medical device manufacturers are ultimately responsible for conducting the necessary testing, research and clinical investigation and scientifically proving the safety and efficacy of medical devices approved by the Food and Drug Administration; and (2) conclusive study and development of Center for Devices and Radiological Health/Office of Science and Technology recommendations regarding safety of article surveillance and other potentially harmful electronic devices with respect to pacemaker use..
Citation: (Res. 507, I-95; Res. 509, A-96; Appended Res. 504, A-99; Reaffirmed: CSAPH Rep. 1, A-09)

Medical Device Amendments of the FDA H-480.996
(1) The AMA reiterates its concerns regarding the implementation of the Medical Device Amendments to the Food and Drug Administration (FDA) and urges that regulations be promulgated or interpreted so as to: (a) not interfere with the physician-patient relationship; (b) not impose regulatory burdens that may discourage creativity and innovation in advancing device technology; (c) not change the character and mandate of existing Institutional Review Boards to unnecessarily burden members of the IRB’s and clinical investigators; (d) not raise the cost of medical care and new medical technology without any concomitant benefit or additional safeguards being provided the patients; and (e) not interfere with patient records’ confidentiality. (2) The AMA urges that existing mechanisms to assure ethical conduct be used to minimize burdensome reporting requirements and keep enforcement costs to a minimum for patients, health care providers, industry and the government.
Citation: (Res. 146, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: BOT Rep. 6, A-10)

Food and Drug Administration H-100.980
(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.
Reference Committee F

BOT Report(s)
10 High Cost to Authors for Open Source Peer Reviewed Publications

Resolution(s)
601 Physician Burnout and Wellness Challenges
REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-I-17

Subject:   High Cost to Authors for Open Source Peer Reviewed Publications
           (Resolution 604-A-17)

Presented by: Gerald E. Harmon, MD, Chair

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

At the 2017 Annual Meeting, the House of Delegates referred Resolution 604, “High Cost to
Authors for Open Source Peer Reviewed Publications,” to the Board of Trustees. Resolution 604,
introduced by the Pennsylvania Delegation, asked:

That our American Medical Association (AMA) investigate the high dollar costs open source
publication rules currently present to the dissemination of research, especially by less well-
funded and/or smaller entities; and

That our AMA make recommendations to correct the imbalance of knowledge suppression
based solely on financial considerations.

It is important to note that the above resolution indirectly addresses the Open Access Movement
(OA) and the fees associated with OA journals. Our AMA publishes some journals that charge
these fees. This report aims to explain OA and our AMA’s involvement with this practice.

Additionally, our House of Delegates has adopted relevant policy. Policy G-630.090, AMA
Publications, “affirms that JAMA and The JAMA Network journals shall continue to have full
editorial independence as set forth in the AMA Editorial Governance Plan.”

BACKGROUND ON THE OPEN ACCESS MOVEMENT

OA refers to research published online that is free of all restrictions on access (e.g., subscriptions
and other usage fees) and of some restrictions of use (e.g., certain copyright and license
restrictions). Widespread public access to the internet in the late 1990s and early 2000s fueled the
OA movement.

Active debate over the economics and reliability of various ways of providing OA continues
among researchers, academics, librarians, university administrators, government officials,
publishers, and editorial staff. Still, OA is gaining acceptance, and many US and all EU research
funders now require that journals offer OA options to the authors supported by their grants.

Conventional non-open access journals cover publishing costs through fees, such as subscriptions,
site licenses, and pay-per-view charges. However, OA journals do not sell subscriptions, charge for
site licenses, or sell advertising. Their only revenue is from Article Processing Charges (APCs),
which help cover costs to review, edit, process, distribute, and host the articles online. These fees
typically range between $3,000 and $5,000 per document. Therefore, OA journals shift the expense of publishing to the investigators and authors.

OPEN ACCESS AND THE JAMA NETWORK®

JAMA does not offer OA in exchange for APCs. All original research articles published in JAMA are made free to everyone six months after the official date of publication, whether or not the research was publicly funded by the National Institutes of Health (NIH). This release date is well within the NIH Public Access Policy’s mandate of 12 months. All specialty journal original research articles are released for public availability after an embargo period of 12 months in accordance with the NIH Public Access Policy.

With the launch of JAMA Oncology in 2015, however, our AMA began to offer an OA option to authors. Through a “hybrid” journal model, authors whose research funders require OA are able to choose the OA option. Our AMA charges APCs around $4,500 to $5,000. However, authors who cannot or do not want to pay for the OA option are not required to pay anything. Approximately 10% of authors to date have chosen the OA option. Generally, funders, not authors, desire OA, and the vast majority of authors select the conventional subscription model.

Because this hybrid model approach appears to balance the demands of funders, changing markets, and business models, it was extended to JAMA Cardiology, which was launched in 2016. This model also recognizes the needs and limited resources of independent researchers and authors. Therefore, the hybrid model approach was applied to all 11 of our AMA’s specialty journals across The JAMA Network on April 1, 2017.

DISCUSSION OF THE RESOLVEDS

The reference committee rightfully believed that our AMA is not in a position to direct or recommend that other medical journal publishers reduce or eliminate their OA fees, especially when fees are a necessary component of OA model journals. Likewise, our AMA cannot instruct international research funders to abandon their OA requirements and support only subscription based journals.

Our AMA Publishing division has investigated the range of OA fees charged by commercial and medical society publishers; the fee charged by The JAMA Network specialty journals falls within this spectrum. The JAMA Network journals require adequate revenue to process, peer review, and publish articles of high quality. As such, current OA fees of $4,500 to $5,000 are reasonable, given journal production and hosting expenses. Moreover, our AMA continues to offer a no-fee option for authors, while providing the OA option for research funders that require and will pay for OA.

Further still, according to a recent investigation commissioned by our AMA, several OA journals, whether purely OA or a hybrid, offer discounts or waivers for their APCs. Discounts or waivers are often considered on a case-by-case basis or offered to authors from low-income or developing countries, based on the HINARI Access to Research Initiative or World Bank figures. This finding highlights the idea that many publishers are cognizant of some authors’ financial hardships and are willing to consider each author on an individual basis.

During testimony on the resolution, concern with “predatory publishers” emerged as a central theme. While this concern about predatory publishers is not found in the resolution itself, it became a significant focus of testimony, with findings and materials on predatory publishers entered into testimony. Predatory publishers, as they have come to be known, hold themselves out as OA
journals and purport to offer traditional services, such as peer review, editing, and publication in return for APCs. Unfortunately, authors soon realize that their submissions receive little or no peer review or that the editors listed are not actually on the editorial board. Further still, some predatory publishers fail to adequately inform authors of any charges or fees before their submissions are approved for publication; some of these publishers deny authors the ability to withdraw their submissions, forcing authors to either pay the fees or make their research ineligible for publication in another journal under academic ethics standards.

Understandably, these predatory publishers pose a great cause of concern for the medical profession and our AMA. While estimates as to the number of predatory publishers vary, the problem has become significant enough for the Federal Trade Commission to take action. On August 25, 2016, the Commission filed a complaint against OMICS Group Inc. and two affiliated companies, alleging that OMICS failed to disclose publishing fees until after submissions were approved for publication and then would not allow researchers to withdraw their articles, invented an Impact Factor and falsely informed authors that their journals are indexed by federal research databases (e.g., PubMed and Medline).

Our AMA has advocated for and will continue to lead the movement for widespread dissemination of medical knowledge and research. *JAMA*’s Key Objective aims “[t]o promote the science and art of medicine and the betterment of the public health.” *JAMA* and its specialty journals are committed to this mission.

**RECOMMENDATION**

The Board of Trustees recommends that Resolution 604-A-17 not be adopted and that this report be filed. AMA Publishing, however, plans to implement a process for waiving or reducing OA fees when authors are not supported by funders or cannot afford to pay OA fees.
Whereas, Burnout affects physicians at all levels of training; 28 to 45% of medical students, 27 to 75% of residents and around 37% of attending physicians experience burnout at various stages of their career;¹⁻² and

Whereas, The consequences of physician burnout are significant. Apart from the emotional and physical toll it takes on the physician and their families, it threatens our U.S. health care system and affects patient safety, quality of care and health care costs; and

Whereas, Depending on age and gender, 6 to 23% of physicians have used non-prescribed opiates, benzodiazepines, alcohol and other substances;³ and

Whereas, A large majority of health care organizations have no programs to prevent or combat physician burnout and promote wellness. Some hospitals have fragmented programs or committees due to lack of support from leadership, administration and budget; and

Whereas, Stanford Medical School and Hospital is the first hospital in the country to appoint a chief wellness officer;⁴ and

Whereas, Mayo Clinic has also implemented a physician well-being program managed by wellness officers;⁵ and

Whereas, Very few medical societies are developing physician wellness and resilience programs; therefore be it

RESOLVED, That our American Medical Association advocate for health care organizations to develop a wellness plan to prevent and combat physician burnout and improve physician wellness (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for state and county medical societies to implement wellness programs to prevent and combat physician burnout and improve physician wellness. (Directive to Take Action)

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

Received: 09/22/17

References:
² Medscape, “Medical Resident Burnout Reaches Epidemic Levels”, May 2015
⁵ Mayo Clinic, “Physician Well-Being Program”, http://www.mayo.edu/research/centers-programs/physician-well-being-program/overview
Reference Committee J

CMS Report(s)
03 Non-Physician Screening Tests
05 Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding

Resolution(s)
801 Chronic Care Management Payment for Patients Also on Home Health
802 Opposition to Medicaid Work Requirements
803 Air Ambulance Regulations and Reimbursements
804 Prior Authorization
805 A Dual System for Universal Health Care in the United States
806 Mandate Transparency by Pharmacy Benefit Managers
807 Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals
808 Opposition to Reduced Payment for the 25 Modifier
809 Expansion of Network Adequacy Policy
810 Pharmacy Benefit Managers and Prescription Drug Affordability
811 Update OBRA Nursing Facility Preadmission Screening Requirements
812 Medicare Coverage of Services Provided by Proctored Medical Students
813 Sustain Patient-Centered Medical Home Practices
At the American Medical Association’s (AMA) 2016 Interim Meeting, the House of Delegates referred Resolution 901, “Disclosure of Screening Test Risk and Benefits Performed without a Doctor’s Order,” submitted by the American College of Radiology, and the Virginia, Alabama, Georgia, Kentucky, District of Columbia, Mississippi, West Virginia, and South Carolina Delegations. 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. Resolution 901-I-16 asked:

That our AMA (1) advocate that if a screening test is being marketed as having a medical benefit and is offered and performed by a wellness program vendor without a specific order by the individual’s physician or other licensed provider, they must provide the patient with the test specific evidence based guidance that supports the utility of the test; (2) advocate that if the procedure is not supported by specific evidence based guidance as a screening test for that patient and the patient still would like the screening test, the Wellness Program Vendor must offer the patient the opportunity to discuss the risks, benefits, and alternatives with a physician licensed to practice medicine in the state in which the test is being performed; (3) engage with federal regulators on whether vendors of health and wellness programs are in compliance with regulations applicable to marketing to patients in view of the impact of such programs on patients; and (4) where possible, continue to work with state medical societies, interested medical specialty societies and state agencies to provide public education regarding appropriate use of vendor wellness programs.

This report provides background on wellness program vendors, particularly focusing on employer-offered wellness programs, discussion on payment for vendor screenings, an overview of the clinical guidelines for screenings, an outline of the relevant legislation, and a series of policy recommendations regarding vendor wellness screenings.

BACKGROUND

Much of today’s health care system was created to provide diagnosis and treatment versus wellness and prevention. However, not only are many diseases preventable but also there are sustained concerns about health care spending. Accordingly, recent years have brought a focus on wellness and prevention. Codified in statutes like the Affordable Care Act (ACA), wellness programs have become a cornerstone in employer and health plan behavior.
More than 5,600 vendors reportedly generate annual revenue of $8 billion in the wellness industry, of which $6 billion is attributable to the workplace wellness industry. Many employers now provide wellness programs to employees in an effort to help employees maintain their health and reduce health care costs. The workplace wellness industry generally consists of vendors that sell companies stand-alone wellness programs or programs that are an optional part of the employee’s health insurance. In addition, some screening services are provided outside of the employer-based wellness program and are often accessed at wellness centers. The Council notes that the scope of this report is limited to basic screenings by a wellness vendor and does not encompass genetic testing. Notably, CMS/CSAPH Joint Report, “Precision Medicine,” also presented at the 2017 Interim Meeting, addresses payment and coverage of genetic testing.

Several companies market wellness screenings, personalized health screenings, and biometric screenings. These services are performed outside of the traditional patient-physician setting and are often marketed to employers as wellness screening programs for their employees. The services provided vary, but they usually include a number of blood tests; ultrasound imaging for conditions, such as abdominal aortic aneurysm, carotid artery disease, and bone density; ankle-brachial index for peripheral artery disease and cardiovascular disease; and sometimes electrocardiogram. Other services include body composition analysis (e.g., body fat percentage, visceral fat, muscle mass and distribution, body water balance, total body weight, body mass index).

The increasing availability of direct-to-consumer screening tests may undermine physician efforts to provide high-quality, cost-conscious screening services to patients through shared decision-making. The wellness vendor screening services at issue are not usually administered by physicians but instead by technicians or other non-physician health professionals outside of traditional health care settings. However, many of these vendor companies have physicians as part of their leadership teams serving as medical directors or members of an advisory board. Some companies are located in retail settings, and others offer services via the internet. Occasionally, the websites of these vendor companies include a disclaimer encouraging those who are interested in testing, or those who have received abnormal test results, to contact their physicians with questions. Some companies offer follow-up with a physician staff member if patients have questions about results.

PAYING FOR WELLNESS SCREENING TESTS

Employers continue to show interest in wellness and screening programs that help employees identify health issues and manage chronic diseases. Therefore, many firms pay for such screenings and tests and some offer financial incentives to encourage employees to complete the health assessments. Many large employers offering health assessments, biometric screenings, and wellness programs offer participating employees lower premium contributions or reduced cost-sharing.

Outside of the workplace wellness program paradigm, health insurance generally does not cover screenings that have not been recommended by physicians. Further, vendors generally make more money the more screenings they perform and therefore often recommend screenings for otherwise healthy people, a practice that has the effect of increasing overall health care costs.

CLINICAL GUIDELINES FOR WELLNESS SCREENINGS

There is concern that the screening services provided by wellness vendors are not always supported by clinical guidelines. Vendor programs do not need to follow screening guidelines from the US Preventive Services Task Force (USPSTF) or other guideline-making bodies. For example, the USPSTF found insufficient evidence to recommend several wellness tests including high sensitivity
C-reactive protein testing for coronary heart disease risk and ankle-brachial index to determine risk for peripheral artery disease and cardiovascular disease. Additionally, concerns exist about providing screening tests to large numbers of patients who may not need them. Wellness programs offer blanket screening tests for nearly anyone while most screening guidelines are tailored based on age, gender, and other factors. For example, the USPSTF recommends abdominal aortic aneurysm screening only in men ages 65-75 who are or have been smokers, and when these guidelines are not followed it leads to unnecessary tests for which a given individual may have no indication. Additionally, the larger the screened population, the higher the number of false positive and false negative results. False positive results could set off a cascade of invasive, expensive, and potentially harmful follow-up tests, and false negative results could lead patients to forego necessary care.

EFFECTIVENESS OF WELLNESS PROGRAMS

The return on investment for wellness programs and screenings is mixed. Often the programs fail to pay for themselves and confer no proven health benefit. Commonly, wellness programs focus on two components: a lifestyle management program and a disease management program. The lifestyle management program focuses on individuals with health risks such as obesity and smoking while the disease management program is designed to help those who already have a chronic disease. Programs focusing on disease management provide a greater return on investment than lifestyle management. Overall, it is estimated that wellness programs reduced average health care costs by about $30 per member per month; however, 87 percent of savings were attributable to disease management programs that focus on interventions for individuals with already-diagnosed conditions in order to reduce complications and related health care utilization. Additionally, it is expensive for employers to pay for wellness program screenings and incentives, and interventions such as subsidizing healthy food choices and reimbursing employees for gym memberships may prove more beneficial.

RELEVANT REGULATIONS

Many states have laws allowing patients to order their own laboratory tests. Additionally, the claims of efficacy made by the vendors are subject to Federal Trade Commission rules on truth-in-advertising, and therefore the claims must be truthful, not misleading, and must be substantiated. Many companies providing these services include language on their websites and other publications stating that test results do not constitute medical advice or diagnoses, thereby limiting their liability.

In response to public health concerns over an unregulated industry, Congress passed the Clinical Laboratory Improvement Amendments (CLIA) to establish standards for diagnostic testing including standards related to safety guidelines, standards to ensure the accuracy and reliability of test results, and standards for laboratory staff, including appropriate level of training. In order to operate, wellness vendors are expected to comply with these guidelines with respect to good practices and may then apply for and receive CLIA certification. Three federal agencies are responsible for the CLIA: The Food and Drug Administration, the Centers for Medicare and Medicaid Services, and the Centers for Disease Control and Prevention. Eighteen states have rules and regulations in addition to CLIA, and some states require vendor licensure in their public health codes.

Additionally, wellness programs must comply with a host of federal laws. These laws include the Employee Retirement Income Security Act (ERISA), the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA), the ACA, and the Health Insurance Portability and Accountability Act (HIPAA). HIPAA applies to wellness programs offered as part...
of an employer’s group health plan. Therefore, information collected from or created about
participants in the wellness program as part of the group health plan is considered personal health
information and is protected by HIPAA.\(^\text{16}\)

**RELEVANT AMA POLICY AND ADVOCACY**

Policy H-425.996 on multiphasic health screening programs states that entities that operate or
sponsor such multiphasic health screening programs should be urged to include in their
promotional and explanatory materials about the availability of the program, a definitive statement
that reports on the screening test results will be furnished to the individual participants only and
that each participant is responsible for obtaining any needed medical evaluation or follow-up
should the results of the tests deviate from the normal range. Those operating or sponsoring
multiphasic health screening programs also should be urged to utilize report forms that state in bold
type that the report does not constitute a medical diagnosis or evaluation and that the participant
should consult a physician of his or her choice if the screening test results are not within the normal
limits indicated on the report. Policy H-425.997 more generally states that preventive care should
ideally be coordinated by a patient’s physician.

Policy H-425.994 states that the evaluation of a healthy person by a physician can serve as a
convenient reference point for preventive services and for counseling about healthful living and
known risk factors and that the testing of individuals should be pursued only when adequate
treatment and follow-up can be arranged for the abnormal conditions and risk factors identified.

To promote continuity of care, Policy H-160.921 states that retail health clinics must establish
protocols for ensuring continuity of care with practicing physicians within the local community and
that retail health clinics should be encouraged to use electronic health records as a means of
communicating patient information and facilitating continuity of care. Further, Policy H-160.921
states that retail health clinics should encourage patients to establish care with a primary care
physician to ensure continuity of care.

Policy D-35.985 recognizes non-physician providers as valuable components of the physician-led
health care team. With respect to the health care team, Policy H-275.976 states that the health
professional who coordinates an individual’s health care has an ethical responsibility to ensure that
the services rendered are provided by those whose competence and performance are suited to
render those services safely and effectively.

Policy H-330.879 on providers and Medicare’s Annual Wellness Visit (AWV) articulates principles
reinforcing the need to protect against vendors fragmenting care and the need to preserve the
physician-patient relationship. Specifically, Policy H-330.879 recognizes the need for safeguards in
such circumstances and states that the AWV is a benefit most appropriately provided by a
physician or a member of the physician-led health care team that establishes or continues to provide
ongoing continuity of care. Further, this policy supports that, at a minimum, any clinician
performing the AWV must enumerate all findings from the visit and make provisions for all
appropriate follow-up care.

**DISCUSSION**

Though well intentioned, the wellness industry often has the effect of duplicating care that
physicians are already providing, unnecessarily increasing physician workload, and obstructing the
physician-patient relationship.\(^\text{17}\) The Council believes wellness programs often incentivize
unnecessary testing and practices that are contrary to evidence-based medicine and medical
judgment. Accordingly, the Council offers a number of principles intended to address these issues and advance the goal of reducing cost of care that does not add value and promoting quality care.

If protections are in place, evidence-based wellness programs can have a positive impact on health by encouraging healthy behaviors and proper disease management strategies. To that end and consistent with the intent of Resolution 901-I-16, the Council recommends that wellness program vendors must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines. Additionally, the Council believes vendors must inform patients of the potential benefits and risks of performing a test and of positive or negative screening test results before a test is performed. The Council believes these principles will help bring vendor practices in line with evidence-based guidelines and aid patients in informed decision-making.

Further, the Council believes it is important that wellness program vendors disclose the qualifications of any individual performing the test as well as those individuals interpreting the test results. Moreover, wellness program vendors should use local physicians as medical directors or supervisors. These recommendations advance the goals of patient education and recognition that physicians are best suited to lead health care teams pursuant to AMA policy. In addition, the Council believes it is important that any policy on vendor screenings limits a physician’s liability and protects against physician administrative burden. To that end, the Council recommends that results of a screening test should only be sent to the individual and that test results showing a positive or otherwise abnormal test result should require a consultation with the patient’s primary care physician or usual source of care. Additionally, the Council recommends that physicians not be held liable for delayed or missed diagnoses indicated on third party vendor tests. The Council believes that this recommendation expressly reaffirms the rule that physician liability be limited when stemming from tests that have not been shared with the physician. Finally, the Council believes that Policy H-425.996 is outdated and that its recommendations herein regarding non-physician screenings supersede the policy and therefore recommends that Policy H-425.996 be rescinded.

The following recommendations complement the body of AMA policy on non-physician tests and care including that on the Medicare Annual Wellness Visit and retail health clinics. The Council approaches this issue with the belief that, if proper safeguards and guidelines are in place, such wellness program vendors can have an appropriate role in the health care system and help advance the goals of better, more cost effective care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 901-I-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-425.994 stating that the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-425.997 stating that preventive care should be coordinated by a patient’s physician and encouraging development of policies and mechanisms to assure the continuity, coordination, and continuous availability of patient care, including preventive care and early-detection screening services. (Reaffirm HOD Policy)
3. That it be the policy of our AMA that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles:

   a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines;

   b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed;

   c. Must disclose the qualifications of any persons in contact with the patient and of any persons interpreting the results of any screening test;

   d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure;

   e. Should send results of any screening only to the individual patient; and

   f. Should require a consultation with the patient’s primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result. (New HOD Policy)

4. That our AMA support that physicians not be held liable for delayed or missed diagnoses indicated on wellness program vendor non-physician ordered screenings. (New HOD Policy)

5. That our AMA rescind Policy H-425.996. (Rescind HOD Policy)

Fiscal Note: Less than $500.
REFERENCES


3 Id.

4 L.V. Anderson. Workplace Wellness Programs are a Sham. Slate. September 2016. Available at: http://www.slate.com/articles/health_and_science/the_ladder/2016/09/workplace_wellness_programs_are_a_sham.html


8 Id.

9 Karen Pollitz and Matthew Rae, supra note 1.

10 Supra note 6.

11 L.V. Anderson, supra note 6.


13 Clinical Laboratory Improvement Amendments (CLIA). U.S. Food and Drug Administration. Available at: https://www.fda.gov/MedicalDevices/DeviceRegulationandGuidance/IVDRegulatoryAssistance/ucm124105.htm

14 Summit Health, supra note 12.


17 Yul Enjes. Workplace Wellness Program Requirements Should Reflect High-Value Recommendations. ACP Internist. Available at: https://www.acpinternist.org/weekly/archives/2017/02/14/5.htm
REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-17

Subject: Reaffirmation of AMA Policy Opposing Caps on Federal Medicaid Funding
(Council on Medical Service Report 9-A-17)

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

At the 2017 Annual Meeting, the House of Delegates referred Council on Medical Service Report 9-A-17, “Capping Federal Medicaid Funding.” The report advocated for a series of safeguards in the event of federal Medicaid funding being capped. Debate on the report focused on an imminent Senate bill to undo the Medicaid expansion of the Affordable Care Act (ACA) and replace it with state per capita caps or block grants.

At the same meeting, the House of Delegates adopted Policy H-290.963, “Federal Medicaid Funding,” which states that our American Medical Association (AMA): (1) opposes caps on federal Medicaid funding; and (2) advocates that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors and other stakeholders, during the process of developing federal legislation, regulations, and guidelines on Medicaid funding.

BACKGROUND

Expanding Medicaid eligibility to most individuals with incomes up to 138 percent of the federal poverty level was a key strategy in expanding health insurance coverage under the ACA and accounted for 63 percent of coverage gains in 2014. Medicaid expansion resulted in an estimated 11 million newly enrolled beneficiaries in 2015. The program currently covers approximately 73 million beneficiaries nationwide. The Medicaid cap safeguards proposed in Council on Medical Service Report 9-A-17 included:

a. Individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced;
b. The amount of federal funding available to states must be sufficient to ensure adequate access to all statutorily required services;
c. Cost savings mechanisms should not decrease patient access to quality care or physician payment;
d. The methodology for calculating the federal funding amount should take into consideration the state’s ability to pay for health care services, rate of unemployment, concentration of low income individuals, population growth, and overall medical costs;
e. The federal funding amount should be based on the actual cost of health care services for each state;
f. The federal funding amount should continue to fund the Affordable Care Act (ACA) Medicaid expansion populations in states that have expanded Medicaid and provide non-expansion states with the option to expand Medicaid with additional funding to cover their expansion populations;
g. The federal funding amount should be indexed to accurately reflect changes in actual health care costs or state-specific trend rates, not on a preset growth index (e.g., consumer price index);
h. Maximum cost-sharing requirements should not exceed five percent of family income; and
i. The federal government should monitor the impact of capping federal Medicaid funding to ensure that patient access to care, physician payment and the ability of states to sustain their programs has not been compromised.

The House of Delegates had a robust discussion about the strategic AMA message that would be implied by adopting the proposed safeguards.

In 2017, Congress considered and defeated numerous proposals to repeal and replace the ACA, which included large (up to $880 billion) reductions to Medicaid and recommendations to cap federal Medicaid spending.

- In March 2017, the American Health Care Act was introduced in the US House of Representatives to repeal and replace the ACA, in part by discontinuing funding for the ACA Medicaid expansion and capping federal Medicaid funding to states.
- In June 2017, during the Annual Meeting of the House of Delegates, the Better Care Reconciliation Act was introduced in the Senate and included a large reduction in federal Medicaid spending, a return to categorical Medicaid eligibility, and a state option to receive a federal block grant for the ACA expansion population of nondisabled adults.
- In July 2017, the Senate considered a “skinnie repeal” bill that left Medicaid intact.
- In September 2017, the Senate considered the Graham Cassidy measure, which would have terminated the ACA’s Medicaid expansions, premium tax credits, cost-sharing reduction payments, and small business tax credits. It would also have imposed per capita caps on Medicaid funding and offered states the alternative of a broader Medicaid block grant.

DISCUSSION

At the time that this report was written, Congress had not taken up additional legislation to repeal and/or replace the ACA. The AMA opposed all of the noted bills and urged Congress to initiate a bipartisan effort to address shortcomings in the ACA. The Council believes the policy adopted at the 2017 Annual Meeting, which opposes caps on federal Medicaid funding, remains relevant and recommends its reaffirmation.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Council on Medical Service Report 9-A-17 and the remainder of the report be filed:

That our American Medical Association Policy H-290.963, “Federal Medicaid Funding,” which opposes caps on federal Medicaid funding, be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.
Whereas, The Centers for Medicare and Medicaid Services (CMS) may reimburse physicians for Chronic Care Management (CCM) services to manage patients with two or more chronic conditions, meeting requirements outlined in Medicare regulations; and

Whereas, When patients are enrolled in home health episodes, physicians in Rural Health Clinics (RHCs) or Federally Qualified Health Centers (FQHCs) are unable to receive CCM reimbursement for treatment or supervision of a patient with chronic conditions under the CCM or home health supervision codes; and

Whereas, Most physicians can receive reimbursement for another service when providing home health supervision, except physicians in RHCs or FQHCs that are unable to receive reimbursement for home healthcare supervision code G0181 (Physician supervision of a patient receiving Medicare covered services provided by a participating home health agency requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans); and

Whereas, For RHCs or FQHCs to provide integrated healthcare as Patient-Centered Medical Homes (PCMH) and provide patients with better health and lower healthcare costs, allowing CCM reimbursement to patients in a current home health episode would align with CMS regulations for CCM; therefore be it

RESOLVED, That our American Medical Association advocate for the authorization of Chronic Care Management (CCM) reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and all other physician clinics providing CCM for patients enrolled in a home health episode, to the Centers for Medicare and Medicaid Services and to Congress if federal law must be amended. (New HOD Policy)

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

Received: 09/19/17
Whereas, An estimated 1.75 million full-time students are currently enrolled in the Medicaid program and are not working;¹ and

Whereas, Several states are in the process of or have formally submitted Section 1115 state waiver requests to include work requirements for Medicaid eligibility;² and

Whereas, The Centers for Medicare and Medicaid Services indicated support for Section 1115 state waiver initiatives involving “training, employment and independence”;³ and

Whereas, Studies have found that Medicaid expansion has had a positive or neutral effect on employment and the labor market;⁴,⁵and

Whereas, Implementation of work requirements would expand the administrative cost of the Medicaid program per enrollee for states while only having a modest benefit to employment that decreases over time when implemented in other programs;²,⁶,⁷,⁸and

Whereas, An estimated 3.43 million non-Supplemental Security Income Medicaid recipients report being too sick to work in addition to 2.74 million non-SSI Medicaid recipients report they couldn’t work because of taking care of their home or family;¹ and

Whereas, A work requirement as a criterion for Medicaid eligibility could bar access to healthcare from vulnerable people too sick to work, acting as caregivers, or unable to find employment;¹ therefore be it

RESOLVED, That our American Medical Association oppose work requirements as a criterion for Medicaid eligibility. (New HOD Policy)

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

Received: 09/20/17

**RELEVANT AMA POLICY**

Proposed Revisions to AMA Policy on Medical Student Debt H-305.928
Medicaid Expansion Options and Alternatives H-290.966
Medicaid - Towards Reforming the Program H-290.997
Giving States New Options to Improve Coverage for the Poor D-165.966
Medicaid Expansion D-290.979
Affordable Care Act Medicaid Expansion H-290.965
Whereas, Air ambulances requested by third-party medical professionals or first responders\(^1\) improve access to level 1 trauma centers for 87 million Americans who would not be able to receive emergent care in a timely manner otherwise, with 86.4% of the U.S. population living within a 15-to-20-minute response area of an air ambulance;\(^1\) and

Whereas, Fifty-nine percent of patients transported by air ambulance had minor injuries, as defined by an Injury Severity Score of less than 15;\(^2\) and

Whereas, The Airline Deregulation Act of 1978 prohibits states from regulating the price, route, or service of an air carrier, including air ambulances, for the purposes of increasing competition, reducing rates, and improving airline passenger service; however, since Medicare’s creation of a national fee schedule for air ambulances in 2002, more than half of the air ambulance industry is controlled by 4 for-profit operators, with an increase in the number of air ambulances from 545 in 2002 to 1,045 in 2015;\(^3,4,5\) and

Whereas, Air Methods, the nation’s largest air ambulance operator, has seen an increase in their average bill of $17,262 in 2009 to $50,199 in 2016, far more than the actual cost for a flight of only $10,199;\(^1,4\) and

Whereas, Lawsuits to collect payment from patients for use of medical helicopters are on the rise;\(^6\) and

Whereas, Medicare only reimburses 59% of air ambulance costs, adding an average of $15,984 to the cost of self-pay or privately insured patients as air ambulance operators recoup what they lose on below-cost transports funded by the government;\(^1\) and

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Whereas, Private insurance companies that offer ambulance coverage only cover an average of 36.5% of the air ambulance’s bill and, unlike Medicare and Medicaid, there are no regulations preventing them from balance billing patients for charges after coverage has been applied;7,8 and
Whereas, Between 2013 and 2016, insurance departments from nine states reviewed 55 incidences in which consumers complained of $3.8 million in combined charges, an average charge of $70,000 per trip;9 and
Whereas, Laws from Wyoming seeking to cap air ambulance fees and North Dakota forcing air ambulance companies to become participating providers by joining major insurance company networks have been struck down in federal courts;10 and
Whereas, The AMA supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems (AMA Policy H-130.954); therefore be it
RESOLVED, That our American Medical Association and appropriate stakeholders study the role, clinical efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate competition, reimbursement, and quality improvement. (Directive to Take Action)

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

Received: 09/20/17

RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954
The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

See also:
H-45.986 Protection of Insurance Coverage for Medical Attendants Aboard Non-Scheduled Aircraft
H-240.978 Medicare’s Ambulance Service Regulations
H-215.973 Emergent Care Adjacent to Hospitals

10 Neary, B. Wyoming seeks to block judge’s order on air ambulance fees. Associated Press. August 2016
Whereas, The cost of health care is ever-increasing; and
Whereas, Employers and other payers are incessantly looking for ways to evaluate the use of certain high-cost medications and services; and
Whereas, One way to do that is to require prior authorization for more and more services; and
Whereas, The additional work required by physician offices has exponentially increased, as witnessed by the need for clinical practices to hire additional employees who spend their total day requesting and arguing for care and services deemed appropriate by the attending physician; and
Whereas, On May 22, 2014, the Centers for Medicare & Medicaid Services released a proposed rule to establish a prior authorization process, endorsing that this would ensure Medicare beneficiaries receive medically necessary care while minimizing the risk of improper payments and therefore protecting the Medicare Trust Fund; and
Whereas, This prior authorization process has been difficult to manage, and has been a significant drain on provider resources--especially at the beginning of each calendar year; and
Whereas, Long-term, effective clinical treatments are frequently required to be re-authorized at the beginning of each calendar year or with any third-party payer change, and often denied with suggestions to take steps backward to previously tried and failed treatments; and
Whereas, This prior authorization process may have worked with some limited cases, but overall, it increases provider burden, complicates patient care and has the potential to cause clinical relapses and worsening medical conditions, which are well-understood by the attending doctor; and
Whereas, Websites with lists of approvable, preferred or otherwise acceptable care and services are neither consistent nor transparent; therefore be it
RESOLVED, That our American Medical Association promote the appropriate use of prior authorization primarily for initial requests and services that fall outside the standard of care (Directive to Take Action); and be it further
RESOLVED, That our AMA implement and promote policy that minimizes the need for prior authorization annually or on any other schedule when the request is for continuity of care and the prior authorization is for regimens that are working well to control a patient’s condition (Directive to Take Action); and be it further

RESOLVED, That our AMA create a policy that prior authorizations need to be completed within three working days by the health plan or pharmacy if approved, or if the prior authorization is denied, the denial must include an explanation, unique and specific to the individual patient, and, if no answer is obtained within three days, the prior authorization is deemed approved and patient care may proceed (New HOD Policy); and be it further

RESOLVED, That our AMA create a policy for the prior authorization process that, unless a health plan, pharmacy vendor or other payer source can document that medical care or a specific service or pharmaceutical is NOT appropriate or medically-indicated based on nationally recognized evidence-based guidelines, the health plan, pharmacy vendor or other payer source shall approve the request of the attending physician (New HOD Policy); and be it further

RESOLVED, That our AMA schedule quarterly meetings with insurance companies to discuss any prior authorization issues, as well as any other matters pertinent to physicians and patients (Directive to Take Action); and be it further

RESOLVED, That our AMA support any effort to allow the physician to bill the insurance company directly for prior authorization time, and that the cost not be a pass-through charge to the patient (New HOD Policy); and be it further

RESOLVED, That our AMA work, both by administrative and/or legislative means, to address the problem of excessive burden from prior authorizations and meaningful use regulations by regulatory and/or legislative means (Directive to Take Action); and be it further

RESOLVED, That our AMA work with Medicare Advantage plans to follow Medicare guidelines if the plan chooses to follow their own guidelines. The plan must be transparent on the criteria for approval or denial. (Directive to Take Action)

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

Received: 09/26/17
Whereas, The delivery and finance of healthcare in the United States is at imminent risk of collapse; and

Whereas, The Affordable Care Act has not stabilized the delivery and finance of healthcare in the United States; and

Whereas, The steadily rising US healthcare expenditures threaten the financial viability of the people, corporations, municipal, state and federal governments of the United States; and

Whereas, The people of the United States have deep philosophical and political divisions regarding the proper reform of our healthcare system; and

Whereas, The achievement of a fully socialized or fully privatized healthcare system is politically impossible and ill-advised given our current status quo; and

Whereas, People of the United States have the freedom to choose the terms under which we receive our healthcare; and

Whereas, We believe it is our right as physicians to choose the terms under which we provide our professional services; and

Whereas, It is our duty as physicians to advocate for quality healthcare services on behalf of all patients who need our services; and

Whereas, The ongoing ideological battle is leading to the failure of both private and government healthcare in the United States; and

Whereas, The ongoing dysfunction in our system is having a severely corrosive effect on the profession of medicine and the patient doctor relationship; and

Whereas, The public and private healthcare systems successfully co-exist in other developed nations; and

Whereas, The public and private services successfully co-exist in other parts of the economy such as transportation, utilities, housing, legal services and education; and

Whereas, It should be politically possible at this moment to craft legislation which forward the agenda and objectives of those who favor a public system and those who favor a private system; therefore be it
RESOLVED, That our American Medical Association vigorously advocate for compromise health care reform legislation which restructures all existing government health care programs into a single universal government system which provides health care to all United States citizens and legal residents at a level which is sustainable and affordable (Directive to Take Action); and be it further

RESOLVED, That our AMA simultaneously, with equal vigor, advocate for a far reaching deregulation of privately purchased health care, while maintaining the emphasis on improving quality and safety (Directive to Take Action); and be it further

RESOLVED, That our AMA resist all legislation which attempts to coerce or infringe upon the freedom of the people of the United States to choose the terms of their health care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for both public and private health care reforms as an inseparable package. (Directive to Take Action)

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

Received: 09/27/17

RELEVANT AMA POLICY

Health System Reform Legislation H-165.838
Individual Health Insurance H-165.920
Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901
Access to Affordable Health Care Insurance through Deregulation of State Mandated Benefits H-180.978
Whereas, There have been numerous documented cases of pharmacy benefit managers (PBM) and local pharmacies charging much higher prices for prescription generic medications if insured, than if these medications were being paid by cash without insurance, thereby raising patient co-pays needlessly;\(^1\,^2\,^3\) and

Whereas, Pharmacy benefit manager’s contracts are cloaked in secrecy, not allowing patients to see the true cost of medications;\(^3\,^4\,^5\) and

Whereas, Such PBM practices drive up the cost prescription medications and insurance cost enriching PBM’s and pharmacies;\(^2\,^3\,^5\) and

Whereas, There is now evidence of widespread price gouging by PBM;\(^4\,^5\) and

Whereas, PBM’s are thinly regulated allowing these abuses to occur;\(^5\,^6\) therefore be it

RESOLVED, That our American Medical Association ask Congress and other appropriate entities to require that there be transparency of drug pricing by pharmacy benefit managers (PBM) to help prevent PBM price manipulation of patient prescription costs (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policy that retail pharmacies and health plans be required to disclose to patients the lowest possible cost of any prescription medication—specifically, any price differential between the price of a drug when using an insurance benefit vs the price of the drug without using that benefit. (Directive to Take Action)

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

Received: 09/28/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 807
(I-17)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

Whereas, Accountable Care Organizations (ACOs) have been promoted for their putative ability to "bend the cost curve" and reduce total medical expenditures; and

Whereas, Physician employment by hospitals has been increasing; and

Whereas, Increasing physician employment has been reported to be a contributor to physician burnout; and

Whereas, "Site of service" payment differentials are causing an unfair advantage favoring hospital employment over independent practice; and

Whereas, Despite early hopes that physicians would lead ACOs, most ACOs are in fact controlled by hospitals and hospital systems; and

Whereas, Hospital-controlled ACOs have sometimes created restrictive referral policies that serve to promote hospital services rather than to seek the lower cost, higher quality, or more accessible location for given service; therefore be it

RESOLVED, That our American Medical Association study and report back on health system-led Accountable Care Organization related barriers to utilizing the site of service determined by the physician to be in the best interest of the patient. (Directive to Take Action)

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

Received: 09/28/17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 808
(I-17)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, Society for Investigative Dermatology, American College of Allergy, Asthma and Immunology, Florida

Subject: Opposition to Reduced Payment for the 25 Modifier

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

Whereas, Several insurers--including Independence Blue Cross, Blue Cross Blue Shield Rhode Island, Harvard Pilgrim Health Care, and Tufts Health Plan--have implemented policies that inappropriately reduce reimbursement for modifier 25; and

Whereas, Anthem announced it will implement the same policy in Kentucky, Ohio and Wisconsin in January of 2018; and

Whereas, When an Evaluation & Management (E/M) code with modifier 25 and a procedure code are billed by the same provider for the same date of service, these plans will only compensate the E/M service at 50 percent of the otherwise allowed amount; and

Whereas, The intent of modifier 25, according to Current Procedural Terminology (CPT) guidelines, is to describe a significant, separately identifiable, and medically necessary E/M service performed on the same day as a procedure, outside of the global fee concept; and

Whereas, Providing medically necessary, distinct services on the same date allows physicians to provide effective and efficient, high quality care, in many cases saving patients a return visit; and

Whereas, The AMA Relative Value Scale (RVS) Update Committee (RUC) already reduces the reimbursement for surgical codes that are typically reported with an E/M to account for any overlapping pre-and post-operative work; and

Whereas, By having an insurer impose a reduction on the E/M service, the insurer is in effect reimbursing both codes at a reduced rate; and

Whereas, If there is not a strong response from the House of Medicine the policy will likely spread to other insurers; and

Whereas, Increased uptake in this policy would lead to reimbursement below the cost of physician expense, patients incurring higher out of pocket costs due to follow up visit, and longer waits to see a specialist; therefore be it
RESOLVED, That our American Medical Association amend Policy D-70.971 by addition and deletion to read as follows:

**Uses and Abuses of CPT Modifier -25 D-70.971**

(1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.

(2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.

(3) Our AMA will collect information on the use and acceptance of modifier -25 among state Medicaid plans and use this information to advocate for consistent acceptance and appropriate payment adjustment for modifier -25 across all Medicaid plans.

(4) Our AMA will encourage physicians to pursue, in their negotiations with third party payers, contract provisions that will require such payers to adhere to CPT rules concerning modifiers.

(5) Our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers and, in the case where a procedure is appropriately modified by a modifier – 25, require that both the procedure and evaluation and management are paid at 100% of the non-reduced, allowable payment rate.

(6) Our AMA will continue to educate physicians on the appropriate use of CPT rules concerning modifiers.

(7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.

(8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.

(Modify Current HOD Policy)

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

Received: 09/29/17

RELEVANT AMA POLICY

**Uses and Abuses of CPT Modifier -25 D-70.971**

(1) Our AMA Private Sector Advocacy Group will continue to collect information on the use and acceptance of CPT modifiers, particularly modifier -25, and that it continue to advocate for the acceptance of modifiers and the appropriate alteration of payment based on CPT modifiers.

(2) The CPT Editorial Panel in coordination with the CPT/HCPAC Advisory Committee will continue to monitor the use and acceptance of CPT Modifiers by all payers and work to improve coding methods as appropriate.

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(7) Our AMA will actively work with third party payers to encourage their disclosure to physician providers any exceptions by those payers to CPT guidelines, rules and conventions.

(8) Our AMA will include in CPT educational publications (i.e. CPT Assistant) examples of commonly encountered situations where the -25 modifier would and would not apply.

BOT Rep. 10, I-03 Reaffirmation A-10
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 809
(I-17)

Introduced by: American Academy of Dermatology, American Society for Dermatologic Surgery Association, American College of Mohs Surgery, American Society of Dermatopathology, Society for Investigative Dermatology, Florida

Subject: Expansion of Network Adequacy Policy

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

Whereas, The Centers for Medicare & Medicaid Services piloted a network adequacy test in 2016 and found several plans with outdated directories; and

Whereas, Exchange plans are required to provide publically available directories and update them on a monthly basis; and

Whereas, Plans continually update networks, but often mistakenly terminate physicians; and

Whereas, As a result of the false termination patients receive notice that the physician chooses to no longer remain in the patient’s network; and

Whereas, In cases where a patient has been informed about the pending termination status of a physician they have seen in the last year that is overturned the patient should receive a corrected notice from the insurer informing them the physician remains available in their selected plan; therefore be it

RESOLVED, That our American Medical Association amend Policy H-285.908 by addition to read as follows:

Network Adequacy H-285.908
12. Our AMA supports requiring that health insurers that terminate in-network providers:
   a) Notify providers of pending termination at least 30 days prior to removal from network.
   b) Give to providers, at least 14 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status. (Modify Current HOD Policy)

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

Received: 09/29/17
RELEVANT AMA POLICY

Network Adequacy H-285.908
1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements.
2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time.
3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received.
4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant’s annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies.
6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities.
7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians’ usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician.
8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks.
9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities.
10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer’s network is limited.
11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.

Citation: CMS Rep. 4, I-14; Reaffirmation I-15; Reaffirmed in lieu of Res. 808, I-15; Modified: Sub. Res. 811, I-15; Reaffirmed: CMS Rep. 03, A-17; Reaffirmed: Res. 108, A-17
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 810
(I-17)

Introduced by: American College of Rheumatology, American Academy of Dermatology, American Academy of Neurology, American Association of Clinical Endocrinologists, American Association of Clinical Urologists, American College of Gastroenterology, American Society of Clinical Oncology, Infectious Diseases Society of America

Subject: Pharmacy Benefit Managers and Prescription Drug Affordability

Referred to: Reference Committee J
(Peter C. Amadio, MD, Chair)

Whereas, Pharmacy benefit managers (PBMs) play a key part in the US prescription drug industry and have significant influence over drug costs and patient access to effective and affordable treatment; and

Whereas, According to a recent poll conducted by the Kaiser Family Foundation, 77% of Americans believe the cost of prescription drugs is unreasonable; and

Whereas, The AMA’s Truth in Rx advocacy campaign is designed to bring attention to rising drug costs and help develop solutions to make prescription drugs more affordable; and

Whereas, Manufacturers pay retroactive rebates to PBMs in exchange for favorable placement on their formularies, which creates perverse financial incentives that motivate PBMs to develop their formularies based on the size of the rebate they can obtain, influence list prices (higher the list price, higher the potential rebate amount), and cause many patients to be denied coverage for their prescribed medication due to an unnecessary formulary restriction; and

Whereas, Patient cost-sharing obligations such as deductibles and coinsurance are calculated based off of the list price and not the actual net price that takes into manufacturer rebates, which greatly increases out-of-pocket costs for the many patients; and

Whereas, Physicians are now held to account for spending per patient episode, and risk being removed from networks based on that spend; and

Whereas, Step therapy, prior authorization, and other utilization management techniques used by insurers and largely stem from the formulary restrictions caused by the rebate system and not only impede patient access to effective and appropriate treatment, but also place a cumbersome and even crippling administrative burden on physicians; and

Whereas, PBM practices have greatly impacted the ability of providers to appropriately treat and effectively care for their patients; therefore be it

RESOLVED, That our American Medical Association expand the Truth in Rx advocacy campaign to include and explicitly address through educational outreach the effects of pharmacy benefit manager (PBM) practices on drug prices and access to affordable treatment (Directive to Take Action); and be it further
RESOLVED, That our AMA engage in efforts to educate federal lawmakers about the role of PBM practices in drug pricing and urge Congressional action to increase transparency of PBM practices (Directive to Take Action); and be it further

RESOLVED, That our AMA work at the federal and state level to increase transparency for PBMs by: eliminating increases in patient cost-sharing obligations for prescription drugs if such drugs are chosen for profit to the PBM; restricting PBM use of non-medical switching and other utilization management techniques related to PBM formulary development that disrupt the patient treatment plan; and further regulating PBM practices in order to ensure patients have access to effective and affordable medication therapies (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model guidelines for effective and meaningful transparency in the rebate system, to include PBM and health plan disclosure to physicians of the contracted cost of medications including discounts and rebates from manufacturers paid back to health plans and PBMs, and urge PBMs to take active steps to implement those guidelines. (Directive to Take Action)

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

Received: 09/29/17

RELEVANT AMA POLICY

Pharmaceutical Cost H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17;

See also: Pharmaceutical Benefits Management Companies H-125.986, Inappropriate Actions by Pharmacies and Pharmacy Benefit Managers D-120.988; Interference in the Practice of Medicine D-125.997; Private Health Insurance Formulary Transparency H-125.979; Expanded Use of the AMA’s Principles of a Sound Drug Formulary H-125.985; Health Plan Coverage of Prescription Drugs D-125.995; Health Plan Coverage of Prescription Drugs D-185.995; Access to Self-Administered Medications H-120.931
Whereas, Preadmission Screening and Resident Review (PASRR) is a federal requirement, which was originally enacted as part of the Nursing Home Reform Act under the Omnibus Reconciliation Act of 1987 (OBRA), designed to protect patients with serious mental illness or intellectual disabilities from lack of access to proper mental health care services and from possible inappropriate admission and retention in nursing facilities; and

Whereas, Although states are required to have a PASRR program whereby applicants to Medicaid-certified nursing facilities receive a comprehensive mental health assessment if they are identified as having a serious mental illness or intellectual disability, there is much variation in how PASRR is implemented across states; and

Whereas, This screening process is comprised of two steps--a Level I screening to identify individuals with a PASRR disability and a Level II screening if the Level I screening indicates an individual may have a serious mental illness or intellectual disability; and

Whereas, The results of the Level II evaluation provide recommendations pertaining to need, appropriate care setting, and necessary specialized services; and

Whereas, The completion time for Level II screening can take up to four to five business days; and

Whereas, Coverage under Medicare Part A funding for a skilled nursing facility (SNF) stay has necessitated a three-day hospital stay in the past, often leading to unnecessarily prolonged lengths of stay for acute inpatient hospitalizations with resultant increases in the total cost of care for many patients; and

Whereas, The development of several payment models such as the Bundled Payment Care Improvement Initiative, Medicare Shared Savings Program Accountable Care Organizations, and other Alternative Payment Models under the Medicare Access and CHIP Reauthorization Act of 2015 has led to a potential waiver of the three-day stay to allow more timely transfer of patients requiring SNF services (sub-acute rehabilitation or long-term care) with a possible reduction in the total cost of care for many patients; and

Whereas, The need for the completion of the PASRR screening prior to admission to a SNF essentially invalidates the potential for more immediate transfers to SNFs from emergency rooms, physicians’ offices, or even other levels of care within the continuum of a nursing facility; therefore be it
RESOLVED, That our American Medical Association work with the US Department of Health and Human Services and Congress to amend applicable statutes and regulations to revise the Preadmission Screening and Resident Review requirement for nursing facility placement to provide more consistent enactment among states and to allow more reasonable and cost-effective approaches to this mandatory screening process. (Directive to Take Action)

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

Received: 09/29/17

RELEVANT AMA POLICY

Direct Admission of Medicare Patients to Skilled Nursing Facilities H-280.977
Our AMA supports regulatory change and any necessary legislation which would delete the 3-day prior hospitalization requirement for provision of skilled nursing facility benefits under Medicare, so as to allow coverage for direct admission of Medicare patients to a skilled nursing facility whether or not they have been discharged from an acute care hospital within the last 30 days.

Citation: (Res. 33, A-91; Res. 48, I-81; Reaffirmed: CLRPD Rep. F, I-91; CMS Rep. 11, I-95; Reaffirmation A-97; Reaffirmation I-00; Reaffirmed: Res. 730, A-06; Reaffirmed: Res. 234, A-09; Reaffirmed: BOT Rep. 32, A-09; Reaffirmation A-11; Reaffirmation A-15)

Three Day Stay Rule H-280.947
1. Our American Medical Association will continue to advocate that Congress eliminate the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services, and educate Congress on the impact of this requirement on patients.
2. Our AMA will continue to advocate, as long as the three-day stay requirement remains in effect, that patient time spent in the hospital, observation care or in the emergency department count toward the three-day hospital inpatient requirement for Medicare coverage of post-hospital skilled nursing facility services.
3. Our AMA will actively work with the Centers for Medicare and Medicaid Services (CMS) to eliminate any regulations requiring inpatient hospitalization as a prerequisite before a Medicare beneficiary is eligible for skilled (SNF) or long-term care (LTC) placement.

Citation: (Sub. Res. 103, A-15; Res. 110, A-15)

Inclusion of Observation Status in Mandatory Three Day Inpatient Stay D-280.989
1. Our AMA will continue to monitor problems with patient readmissions to hospitals and skilled nursing facilities and recoding of inpatient admissions as observation care and advocate for appropriate regulatory and legislative action to address these problems.
2. Our AMA will continue to advocate that the Centers for Medicare & Medicaid Services explore payment solutions to reduce the inappropriate use of hospital observation status.

Citation: (BOT Rep. 32, A-09; Appended: CMS Rep. 4, A-14)

Observation Status and Medicare Part A Qualification D-280.988
Our AMA will advocate for Medicare Part A coverage for a patient's direct admission to a skilled facility if directed by their physician and if the patient's condition meets skilled nursing criteria.

Citation: (Res. 117, A-13; Reaffirmed: CMS Rep. 4, A-14; Reaffirmation A-15)

Three Day Prior Hospital Stay Requirement H-330.948
Our AMA will recommend that the Secretary of the U.S. Department of Health and Human Services, in consultation with health care professionals and skilled care providers, define a subset of patients (or DRGs) for whom the elimination of the three day prior hospital stay requirement for eligibility of the Medicare Skilled Nursing Facility benefit would avert hospitalization and generate overall cost savings.

Citation: (Res. 805, I-93; Reaffirmation A-97; Reaffirmation I-00; Reaffirmation A-04; Reaffirmed: Res. 234, A-09; Reaffirmation A-11)
Whereas, Current trends in medical education in the US often lead to medical students providing medical services under the practiced eyes of proctoring medical professionals (both teaching physicians and other health care providers such as medical assistants and respiratory therapists); and

Whereas, Services provided by intern or resident physicians are billable under Centers for Medicare and Medicaid Services (CMS) through the Medicare Physician Fee Schedule if a teaching physician is physically present during the critical or key portions of the service; and

Whereas, Services provided by medical students (such as obtaining a Pap smear or setting up a nebulizer treatment) are not currently billable under CMS even if proctoring medical professionals are directly assisting or overseeing the service as part of medical education; and

Whereas, The inability to bill for these services may result in unnecessary duplication of services for patients, including the potential risk of repetitive minor procedures; and

Whereas, The inability to bill for these services may also result in restrictions in medical student education access since the educational facility may not be able to sustain the educational process without the procedural revenue; therefore be it

RESOLVED, That our American Medical Association amend Policy, H-390.999, “Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries,” by addition as follows:

When a physician assumes responsibility for the services rendered to a patient by a medical student, a resident, or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with the Centers for Medicare and Medicaid Services to require coverage of medical services performed by medical students while under the physician's personal observation, direction, and supervision. (Directive to Take Action)

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

Received: 09/29/17
RELEVANT AMA POLICY

Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries H-390.999
When a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision.

Clinical Proctoring H-375.974
AMA policy states that clinical proctoring is an important tool for education and the evaluation of clinical competence of new physicians seeking privileges or existing medical staff members requesting new privileges. Therefore, the AMA:
(1) encourages hospital medical staffs to develop proctoring programs, with appropriate medical staff bylaws provisions, to evaluate the clinical competency of new physicians seeking privileges and existing medical staff members requesting new privileges; and
(2) encourages hospital medical staffs to consider including the following provisions in their medical staff bylaws for use in their proctoring program:
(a) Except as otherwise determined by the medical executive committee, all initial appointees to the medical staff and all members granted new clinical privileges shall be subject to a period of proctoring.
(b) Each appointee or recipient of new clinical privileges shall be assigned to a department where performance of an appropriate number of cases as established by the medical executive committee, or the department as designee of the medical executive committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine the suitability to continue to exercise the clinical privileges granted in that department. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee.
(c) The members shall remain subject to such proctoring until the medical executive committee has been furnished with: a report signed by the chair of the department(s) to which the member is assigned as well as other department(s) in which the appointee may exercise clinical privileges, describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogative of the category to which the appointment was made, and that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.
Citation: (BOT Rep. 30-A-94; Amended: CMS Rep. 3, A-99; Reaffirmed: CLRPD Rep. 1, A-09)

Supervision and Proctoring by Facility Medical Staff H-375.967
Our AMA advocates that the conduct of medical staff supervision be included in medical staff bylaws and be guided by the following principles:
(1) Physicians serving as medical staff supervisors should be indemnified at the facility's expense from medical practice claims and other litigation arising out of the supervision function.
(2) Physicians being supervised should be indemnified at the facility's expense for any damages that might occur as a result of implementing interventions recommended by medical staff supervisors.
(3) AMA principles of peer review as found in Policies H-320.968 [2,d], H-285.998 [5], and H-320.982 [2c,d] should be adhered to in the conduct of medical staff supervision.
(4) The medical staff member serving as supervisor should be determined through a formal process by the department chair or medical staff executive committee.
(5) The scope of the medical staff supervision should be limited to the provision of services that have been restricted, are clearly questionable, or are under question, as determined by the department chair or medical staff executive committee.
(6) The duration of the medical staff supervision should be limited to the amount of time necessary to adequately assess the degree of clinical competence in the area of skill being assessed.
(7) Medical staff supervision should include a sufficient volume of procedures or admissions for meaningful assessment.
(8) Medical staff supervisors should provide periodic performance reports on each patient to the appropriate designated medical staff committee. The reports should be transcribed or transected by the medical staff office to assure confidentiality. The confidentiality of medical staff supervision reports must be strictly maintained.
(9) Physicians whose performance is supervised should have access to the performance reports submitted by medical staff supervisors and should be given the opportunity to comment on the contents of the reports.
Citation: (CMS Rep. 3, A-99; Reaffirmed: CLRPD Rep. 1, A-09)
Whereas, The Patient-Centered Medical Home (PCMH) practice model has been implemented throughout the health care delivery system for several years; and

Whereas, Third-party payers are benefiting from the hard work of physicians; and

Whereas, The ongoing costs to physicians to sustain PCMH are significant; therefore be it

RESOLVED, That our American Medical Association amend Policy, H-160.918, “The Patient-Centered Medical Home,” by addition as follows:

Our AMA:
1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for and sustain medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings—such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C)—and not be subject to a budget neutrality offset in the Medicare physician payment schedule; and
4. will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA work with and encourage the Centers for Medicare and Medicaid Services to subsidize the cost of sustaining Patient-Centered Medical Home designated practices for practicing physicians. (Directive to Take Action)

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

Received: 09/29/17
RELEVANT AMA POLICY

The Patient-Centered Medical Home H-160.918
Our AMA:
1. will urge the Centers for Medicare and Medicaid Services (CMS) to work with our AMA and national medical specialty societies to design incentives to enhance care coordination among providers who provide medical care for patients outside the medical home;
2. will urge CMS to assist physician practices seeking to qualify for medical home status with financial and other resources;
3. will advocate that Medicare incentive payments associated with the medical home model be paid for through system-wide savings--such as reductions in hospital admissions and readmissions (Part A), more effective use of pharmacologic therapies (Part D), and elimination of government subsidies for Medicare Advantage plans (Part C)--and not be subject to a budget neutrality offset in the Medicare physician payment schedule; and
4. will advocate that all health plans and CMS use a single standard to determine whether a physician practice qualifies to be a patient-centered medical home.

Citation: (CMS Rep. 8, A-09)

See also: Principles of the Patient-Centered Medical Home H-160.919
Reference Committee K

CSAPH Report(s)

01 Universal Color Scheme for Respiratory Inhalers
02 Targeted Education to Increase Organ Donation
03 Neuropathic Pain as a Disease
04 National Drug Shortages Update

Resolution(s)

901 Harmful Effects of Screen Time in Children
902 Expanding Expedited Partner Therapy to Treat Trichomoniasis
903 Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals
904 Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients
905 Addressing Social Media Usage and its Negative Impacts on Mental Health
906 Opioid Abuse in Breastfeeding Mothers
907 Addressing Healthcare Needs of Foster Children
908 Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability
909 Expanding Naloxone Programs
910 Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination
952 Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training
953 Fees for Taking Maintenance of Certification Examination
954 Developing Physician Led Public Health / Population Health Capacity in Rural Communities
955 Minimization of Bias in the Electronic Residency Application Service Residency Application
956 House Physicians Category
957 Standardization of Family Planning Training Opportunities in OB-BYN Residencies
958 Sex and Gender Based Medicine in Clinical Education
Subject: Universal Color Scheme for Respiratory Inhalers (Resolution 906-I-16)

Presented by: Robert Gilchick, MD, MPH, Chair

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

INTRODUCTION

Resolution 906-I-16, “Universal Color Scheme for Respiratory Inhalers,” introduced by the Resident and Fellow Section and referred by the House of Delegates asked:

That our American Medical Association work with leading respiratory inhaler manufacturing companies and health agencies such as the Federal Drug Administration and the American Pharmacists Association to develop consensus of a universal color scheme for short-acting beta-2 agonist respiratory inhalers that are used as “rescue inhalers” in the United States;

That our AMA work with leading respiratory inhaler manufacturing companies to ensure the universal color scheme for respiratory inhalers would allow for the least disruption possible to current inhaler colors, taking into account distribution of each brand and impact on current users if color were to change;

That our AMA work with leading respiratory inhaler manufacturing companies to ensure that universal color scheme for respiratory inhalers be designed for adherence and sustainability, including governance for future companies entering the respiratory inhaler market, and reserving colors for possible new drug classes in the future.

Traditionally, in the United Kingdom, Canada, and parts of Europe short-acting β₂-adrenergic agonist (SABA) respiratory inhalers are colored blue and referred to as “relievers” or “rescuers,” while inhaled corticosteroids (ICS) are colored brown, orange, or red and are referred to as “preventers” or “controllers.” No convention exists in the United States for the coloration of respiratory inhalers.

CURRENT AMA POLICY

Policy H-115.980, “Distinctive Labeling of Vials and Ampules, Prefilled Syringes, Ophthalmic Solutions and Related Liquid Medications,” is somewhat related to this resolution, calling for the development of appropriate guidelines aimed at developing easily identifiable labeling to optimize the safe use of liquid medication. No current AMA policy related to color coding of respiratory inhalers exists.
METHODS

English-language articles were selected from a search of the PubMed database through July, 2017 using the search term “inhaler” coupled with “color” and “colour.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify relevant clinical guidelines, position statements, and reports.

COLOR CODING

Color coding is the systematic, standard application of a color system to aid in the classification and identification of drug products. Conceptually, a color coding system allows users to associate a color with a function. Color coding as an aid to patient safety requires the use of consistent coloring schemes by all manufacturers.

Color Coding and Medication Errors

In a 2004 report, titled “The Role of Color Coding in Medication Error Reduction,” the Council on Scientific Affairs (CSA) (predecessor to the Council on Science and Public Health) noted controversy among experts and a variety of potential problems with color coding of pharmaceutical products, which suggest that a universal color scheme should not be universally adopted. Several organizations involved in medication error prevention, including the American Society of Health-System Pharmacists (ASHP), Institute for Safe Medication Practices (ISMP), U.S. Food and Drug Administration (FDA), and the pharmaceutical industry either oppose color coding or recommend caution in its application. The report also noted a lack of evidence proving that color coding reduces medication errors; this lack of evidence still exists.

The result of the CSA report was a directive that was sunsetted in 2014 after AMA provided testimony to the FDA regarding the report’s findings, which identified potential problems associated with the color coding of pharmaceutical products. The FDA released a draft guidance in 2013, entitled “Safety Considerations for Container Labels and Carton Labeling Design to Minimize Medication Errors.” The draft guidance recommends avoiding color coding in most instances and goes on to note that “[c]olor coding schemes developed to decrease error may actually increase error when the color is relied upon as a shortcut to proper identification (i.e., not reading the label).” FDA intends to finalize this guidance.

FDA notes limited applications of color coding that are appropriate and were established before the 2013 guidance document, such as the caps of ophthalmic solutions that indicate the therapeutic class of a drug. These classifications, however, are generally not useful to end users outside of ophthalmology and these color classifications have caused problems with users having difficulty differentiating between drugs within the same therapeutic class. Additionally, the color-coding of surgical anesthesia syringes has been adopted with the intention of reducing the risk of accidental syringe swapping by surgical users, but limited evidence has not shown that drug errors have been eliminated. In both examples, the end user populations are limited groups, not a large outpatient patient population.

Additional Disadvantages of Color Coding of Pharmaceutical Products

In addition to the lack of scientific evidence that proves color coding reduces medication errors, experts in the field of medication errors also cite other reasons why the widespread adoption of
color coding systems for pharmaceutical products should be done with great caution.\textsuperscript{1,3,5,6,9-12} Potential problems include:

- There is a limit to the number of discernable colors available for commercial use.
- Subtle distinctions in color are poorly discernable unless products are adjacent to one another.
- Color coding of drug classes can increase the chance of “intraclass” medication errors.
- Colors may fade when exposed to light.
- It is not always possible to exactly reproduce Pantone colors from batch to batch.
- Approximately 8\% of men and fewer than 1\% of women have some difficulty with color vision (colorblindness).
- Color coding can be error-prone if it is not applied consistently across the industry, or within a single manufacturer’s product line.
- Physicians and other health professionals may be unable to remember large or multiple-color coding systems.
- Color coding may offer a false sense of security and, in some instances, result in failure of the physician or other health professional to “read the label.”

COLOR CODING OF RESPIRATORY INHALERS

The coloring of outpatient SABA inhalers as blue and ICS as brown/red/orange in the United Kingdom and Canada is an informal convention that has been an accepted practice for several decades. No regulations have been issued by the United Kingdom Medicines and Healthcare Products Regulatory Agency, the European Medicines Agency, or Health Canada, and no formal agreement exists for manufacturers, regarding a color convention for respiratory inhalers. As a general principle, the three health agencies recommend against color coding.\textsuperscript{9,13,14} The European Medicines Agency has stated that “there can be no substitute for carefully reading the label before any medicine is taken.”\textsuperscript{15} Color of inhalers is not addressed in guidelines for the management of asthma.\textsuperscript{16,17}

With the increasing diversity of inhaler devices, including combination products, entering the market in the United Kingdom and Canada, color coding is becoming more complex and inconsistent. The recent Health Canada approval of a long-acting $\beta_2$-adrenergic agonist (LABA) and ICS combination inhaler in the color blue\textsuperscript{18} has raised concerns.\textsuperscript{19} The existence of a generic salbutamol (a SABA) inhaler in brown in the United Kingdom adds confusion to the color coding convention.\textsuperscript{15} Manufacturers have been called on to consider universal concepts such as color coded dots or bands that correspond to different types of medications.\textsuperscript{20} However, the aforementioned disadvantages of color coding pharmaceutical products such as colorblindness and limited color availability persist and no formal action has been taken to ensure universal concepts.\textsuperscript{21}

Color Coding Respiratory Inhalers and Patient Adherence

A small survey of health care professionals in the United Kingdom found that the existing color convention for inhalers appears to be helpful in aiding communication between health care professionals and patients and can be helpful for reinforcing the different roles of inhalers and aiding in medication adherence.\textsuperscript{13} However, it should be noted that this communication between patients and physicians regarding inhaler color in the United Kingdom is likely aided by the color convention that has existed and been known for decades. A parallel situation of familiarity with a color convention does not exist for patients in the United States. The authors of the survey also noted a lack of studies regarding color-standardization in general and specific issues surrounding color coding such as color blindness.
Poor adherence to maintenance therapy is common among asthma patients and a complex challenge to overcome. Individualized action plans developed in a collaborative fashion between asthma patients and their physicians that focus on self-management are typically employed to promote adherence and appropriate clinical use of different inhalers. Inhaler color was of little importance in action plan discussions; emphasis was placed on when to use medications, skills training for use of inhalers, and education for asthma symptom management.

CONCLUSION

Although looked to for simplicity, limited evidence exists that color coding systems reduce medication errors in outpatients. Disadvantages of using color coding systems have been cited and experts either oppose color coding or recommend caution in its application. The FDA, Health Canada, and health agencies in the United Kingdom emphasize the best course of action before administration of any medication is to read the label. Even though the health agencies of United Kingdom and Canada recommend against color coding, an informal respiratory inhaler color coding convention exists in these countries. However, because of continued development of new products, including combinations, this color coding convention is becoming inconsistent and more complex. Experts evaluating the adherence of patients using inhalers have suggested that individualized counseling with personalized action plans and inhaler skills training are the best approach for improving adherence. With the lack of evidence to support a color coding scheme for outpatient respiratory inhalers, there is no justification for urging manufacturers to change inhaler colors, the potential cost associated with such a change which may be passed along to patients, and disruption to the current market of familiar inhaler products.

RECOMMENDATION

The Council on Science and Public Health recommends that the following statement be adopted in lieu of Resolution 906-I-16, “Universal Color Scheme for Respiratory Inhalers,” and the remainder of the report be filed:

Our American Medical Association supports research into mechanisms to improve patient understanding of their respiratory inhaler medications with the aim of improving safety and reducing unintentional medication errors, such as inhaler skills training and individualized action plans. (New HOD Policy)

Fiscal Note: Less than $500
REFERENCES


EXECUTIVE SUMMARY

Background. This report responds to Policy D-370.984 by reviewing current organ donation statistics, attitudes about donation, the disproportion between those needing a transplant and the organs available, factors influencing the decision to designate oneself as a donor, and educational interventions targeted to segments of the population with historically low rates of organ donation.

Methods. Literature searches were conducted in the PubMed database for English-language articles published between 2007 and 2017 using the search term “organ donation,” with the terms “minority,” “religion,” “education,” and “barriers.” A Google search was conducted using the same search terms. Additional articles were identified by manual review of the references cited in identified publications. The Health Resources and Services Administration (HRSA) Organ Donation and Transplantation and Organ Procurement and Transplantation Network websites, and the United Network for Organ Sharing website also were consulted.

Results. More than 33,000 transplants were performed in 2016, with kidney and liver transplants making up the majority. Most adults in the United States report supporting organ donation, yet only about half are registered as organ donors. Small but significant differences in support for organ donation and registration as an organ donor exist among certain racial and ethnic groups. Factors influencing support for organ donation are relational ties, religious and cultural beliefs, family influence, beliefs about body integrity after death, prior experience with the health care system, and knowledge about organ donation. Several educational programs addressing these factors and targeted to populations with low organ donation rates have been conducted in community and church settings, and have been variably successful in improving knowledge and positive perceptions about organ donation and intent to donate.

Conclusion. Although the number of organ donors and transplants has grown over the last two decades, the need for donated organs still far exceeds the number available for transplantation. This disparity is especially true for certain racial and ethnic minorities that make up a larger proportion of the transplant waiting list compared to their relative proportion among organ donors. Educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates have been developed to improve donation. Those that have been successful should be continued and expanded to improve organ donation rates among populations most in need. In addition to targeted educational programs, successful non-targeted educational programs and other approaches should be continued as well.
INTRODUCTION

Policy D-370.984, “Targeted Education to Increase Organ Donation,” asked:

That our American Medical Association study potential educational efforts on the issue of organ donation tailored to demographic groups with low organ donation rates.

This report responds to Policy D-370.984 by reviewing current organ donation statistics, attitudes about donation, disproportion between those needing a transplant and the organs available, factors influencing the decision to designate oneself as a donor, and educational interventions targeted to segments of the population with historically low rates of organ donation. Other factors affecting organ donation rates, including mandated choice and presumed consent for donation of cadaver organs, as well as novel models for living donation, have been discussed in Board of Trustees Reports 13-A-15 and 15-A-12.1,2

METHODS

Literature searches were conducted in the PubMed database for English-language articles published between 2007 and 2017 using the search term “organ donation,” with the terms “minority,” “religion,” “education,” and “barriers.” A Google search was conducted using the same search terms. Additional articles were identified by manual review of the references cited in identified publications. The Heath Resources and Services Administration Organ Donation and Transplantation and Organ Procurement and Transplantation Network websites and the United Network for Organ Sharing website also were consulted.

ORGAN DONATION STATISTICS AND ATTITUDES

Donated organs and tissues for transplantation are most often obtained from deceased donors, referred to as deceased organ donation. Deceased organ donors can donate kidneys, liver, lungs, heart, pancreas, and intestines. In addition to these organs, tissues such as heart valves, skin, bone, and tendons; corneas; and face and hands can be donated after death. Approximately 90% of organ donations are from deceased donors; the remaining donations are from living donors. Organs donated by living donors include one of two kidneys, one of two lobes of the liver, a lung or part of the lung, part of the pancreas, and part of the intestines. Tissues donated by living donors include skin, bone, bone marrow cells and umbilical cord blood cells, amniion (donated after childbirth), and blood. More than 33,000 transplants were performed in 2016. Kidney and liver transplants made up the vast majority of organs transplanted (approximately 58 and 23 percent, respectively).
Less common transplants were heart (9 percent), lung (7 percent), kidney and pancreas (2 percent), pancreas (0.7 percent), intestine (0.5 percent), and heart and lung (0.05 percent).4

Organ and tissue donation in the United States is voluntary. Individuals wishing to donate their organs after death “opt in” by documenting their desire. Deceased organ donation registration is a state process; individuals can sign up online with the state registry or through a state’s Department of Motor Vehicles. When the person’s preferences are not documented or known, the next of kin may decide to allow organs to be harvested for transplantation after death.5 More than 130 million adults in the United States (approximately 54% of the population) are registered as organ and tissue donors.4

Living organ donation is not administered through state or other government programs. Rather, it most often occurs in the form of directed donation, in which the donor names a specific person to receive the organ or tissue, usually a biological relative or a biologically unrelated person with a personal or social connection (spouse, significant other, friend, or acquaintance).7 In non-directed donation, the living organ donor does not name a recipient. Those wishing to be non-directed donors can do so by contacting a designated Organ Procurement and Transplant Network (OPTN) transplant center, or by contacting the United Network for Organ Sharing (UNOS).7

A 2012 survey of a nationally representative sample of US adults, administered by the Health Resources and Services Administration (HRSA), examined organ donation attitudes and behaviors. More than 95 percent of respondents supported or strongly supported the donation of organs for transplantation.8 Small but significant differences in support exist among racial and ethnic groups. Approximately 95 percent of those categorizing themselves as White, Asian/Pacific Islander, or Hispanic support or strongly support donation, while approximately 92 percent of Native Americans and 87 percent of African Americans support or strongly support donation.8 Despite strong support for organ donation, the survey indicated that fewer people took steps to register as organ donors; only 60 percent of respondents with a driver’s license reported that they had granted permission for organ donation on their driver’s license.8 Racial and ethnic differences were apparent on this measure as well; 65 percent of White, 56 percent of Asian/Pacific Islander, 47 percent of Native American, 44 percent of Hispanic, and 39 percent of African-American respondents with a driver’s license reported that they had granted permission for organ donation on their license.8

ORGAN DONATION NEEDS

Although the number of both donors and transplants has been growing slowly over the last two decades, the need for donated organs far exceeds the number available for transplantation. Nearly 120,000 people are on the national transplant waiting list, with the vast majority (81 percent) waiting for a kidney.4 Only about three in 1,000 registered donors actually become donors after death. This is due to a number of criteria that must be met for a donor organ to be appropriate for an intended recipient (the “matching” process). These include blood and human leukocyte antigen (HLA) type, body size, severity of the recipient’s medical condition, severity of donor’s pre-death medical condition, length of time on the waiting list, distance between the donor’s and recipient’s hospitals, and the availability of the recipient.9

The proportion of racial and ethnic minority patients on the waiting list is higher than the corresponding proportion of racial and ethnic minorities who are donors.4 For example, African Americans make up nearly 30 percent of patients on the waiting list, but only approximately 16 percent of donors are African American.4 Hispanics and Asians make up nearly 20 and 8 percent, respectively, of patients on the waiting list, but only approximately 14 and 3 percent of donors are
Hispanics and Asians, respectively. This disparate representation on the transplant waiting list exists partially because minority groups, specifically African Americans, are disproportionately impacted by chronic conditions such as diabetes, heart disease, and hypertension, which often are managed with transplants. Additionally, African Americans have more HLA polymorphisms and enhanced alloreactivity, making the chance of finding a matching donor, especially among a pool of donors that includes proportionally fewer African Americans, particularly difficult.

FACTORS INFLUENCING ORGAN DONATION

Irving et al. conducted a systematic review of studies that characterized factors influencing attitudes toward deceased and living organ donation, and categorized the factors into several broad themes:

- Relational ties: The needs of family members or friends appear to be more influential in the decision to become a donor than those of strangers. Many study participants were willing to donate an organ to a family member or friend even if they were not willing to donate to someone they did not know.

- Religious beliefs: While some believe that organ donation aligns with the altruistic tenets of their religion, others believe that donation is not consistent with their religion. For example, some Islamic study participants interpret the Qur’an and traditional Islamic literature as forbidding organ donation. Others believe that transplantation, and therefore the facilitation of transplantation through organ donation, is “playing God.” The most common religious objection to organ donation was the need to maintain body wholeness to enter the next life.

- Cultural beliefs: Cultural beliefs concerning health care and death and dying, often based on superstition, are associated with lack of support for organ donation. For example, study participants cited the belief among some cultures that discussing death could lead to one’s own death. Others believe that death is a private matter, that ancestral approval is needed before organ donation, and that grieving rituals are disrupted by organ donation.

- Family influence: Family members’ beliefs about organ donation often influence individual beliefs. Study participants with one or both parents who object to organ donation expressed reluctance to be donors themselves, and some participants believed that they should seek permission from family members if they wanted to be donors. Other participants believed that by designating themselves as organ donors, they were sparing their family members difficult decisions after their death.

- Body integrity: Apart from religion, body integrity after death appears to influence support for donation. Participants worried that family members would be traumatized about the thought of their bodies being “cut up,” and that organ donation would preclude an open coffin at their funeral.

- Interaction with the health care system: A distrust of the organ donation system and process, often based on negative experiences with the health care system, reduce support for organ donation. Participants questioned the concept of “brain death,” and were suspicious of health care providers making such a designation. Some believed that organ donors would not receive proper care since health care personnel would only be interested in harvesting their organs, or that donor bodies would not be treated with dignity and
respect. Opinions based on previous experience or interactions with the health care system were more prevalent among study participants belonging to minority groups that have historically experienced a sense of marginalization from the health care system.

- Knowledge about the organ donation process: A lack of knowledge about the organ donation process is a barrier to donation. Study participants expressed the need for more information before they could commit to donation, and a lack of awareness about where such information could be obtained.

Across a number of studies assessing characteristics of those willing to donate, individuals who are younger, are female, have higher educational levels and/or socioeconomic status, and have higher knowledge about organ donation are generally more likely to have positive attitudes toward donation and are more willing to donate. The HRSA organ donation attitudes and behaviors survey found that the following attitudes were predictors of designating oneself as an organ donor: placing low importance on body wholeness after death, family support for organ donation, being receptive to receiving a transplant as a life-saving measure, an understanding that many people die while on the transplant waiting list, and not believing the notion that physicians would be less likely to save the life of a person who is a donor.

Some factors influencing support for organ donation are more pronounced in certain racial or ethnic groups than in others. For example, interviews with African Americans found the following as predominant barriers: religious beliefs and misperceptions, distrust of the medical establishment, fear of premature declaration of death if a donor card has been signed, and a preference among African American donors for assurance that the organs will be given preferentially to African American recipients. In Native Americans, the importance of traditional religious beliefs, including the need to be buried with an intact body, is a barrier to deceased organ donation. Among Hispanics, greater concern over body disfigurement and greater doubt that physicians do all they can to preserve life before pursuing organ donation exist compared to non-Hispanic whites.

It is unclear that religion itself is a consistent barrier to organ donation. The role of religion in support for organ donation is often confounded by community and cultural norms. In international studies, Buddhists have reported objection to deceased organ donation based on the religious belief that a person’s spirit remains in the body as long as the heart is still beating, even though brain death has occurred. This is despite a central Buddhist tenet that honors persons who donate their organs to save a life. Studies of Muslims have indicated that religious beliefs are a barrier to organ donation, and in the United States, Muslims who demonstrate negative aspects of religious coping (a psychological state in which individuals express an insecure relationship with God and an ominous view of the world) are more likely to hold negative attitudes toward organ donation. However, other measures of Muslim religiosity are not correlated with organ donation attitude, and many Muslims in the United States believe that donation is justified. Among Christians, non-Catholic Christians are more likely to report willingness to be organ donors than are Catholic Christians.

TARGETED EDUCATIONAL INTERVENTIONS TO INCREASE DONATION

Given the significant need to increase the number of organs available for donation, educational interventions are needed to improve willingness to donate. Ideal interventions include those that address perceptions that influence the decision to donate and target populations most likely to hold such perceptions. A systematic review of interventions to improve organ donor registration among minorities found that educational interventions alone or combined with mass media
approaches (as opposed to mass media alone) were most effective.\textsuperscript{25} Those that included strong interpersonal components, were delivered by members of the local community in familiar environments, and included immediate opportunities to register were important for improving outcomes.\textsuperscript{25} Others have emphasized culturally appropriate strategies to engage minority groups, and comprehensive information about organ donation that can be easily obtained.\textsuperscript{14} A recent study examining factors that may facilitate the willingness of African Americans to become organ donors determined that improving knowledge about organ donation, particularly with regard to donor involvement and donation-related risks, may be successful in increasing organ donation.\textsuperscript{26}

Examples of national, church-based, and community-based targeted educational interventions are summarized below. It is important to note that although some interventions appear to have been successful in improving knowledge and attitudes about organ donation, discussion of organ donation with family members, and changing organ donor status, it is generally difficult to measure intervention success because of concurrent programs that directly or indirectly affect organ donation.\textsuperscript{27} For example, policies aimed at motorcycle helmet use, health system transformation, public health spending, smoking rates, and chronic disease affect the health of the donor pool, which in turn could affect the number of organs available for donation.\textsuperscript{27}

\textit{Nationally Targeted Interventions}

The National Minority Organ Tissue Transplant Education Program (MOTTEP) was created in 1991 with a mission to decrease the number of ethnic minority Americans on transplant waiting lists.\textsuperscript{17,28,29,30} Fifteen national sites were funded to carry out community-based programs that centered on approaches including community participation and direction to target specific community differences; face-to-face presentations, especially to smaller audiences to foster discussion; collaboration and partnerships with religious, social, and civic organizations; media promotion of MOTTEP’s message; dissemination of culturally sensitive and informative brochures, videos, public service announcements, and other information; and comprehensive evaluation to gauge effectiveness of the program.\textsuperscript{17,29,31} The number of organs recovered for transplantation from African Americans increased more than 3-fold between 1991 and 2016, with some suggesting the success is partially due to MOTTEP efforts.\textsuperscript{29,31,32}

\textit{Church-Based Targeted Interventions}

Another educational program targeting African Americans, Project ACTS (About Choices in Transplantation and Sharing), was a self-administered donation education intervention developed with a focus on addressing religious barriers to donation and encouraging family discussion.\textsuperscript{33} The program consisted of materials distributed at churches that are taken home and reviewed individually. The materials included a video hosted by a gospel choir with excerpts from individual and family conversations about beliefs, attitudes, myths, misconceptions, and fears about organ donation/transplantation; an educational pamphlet; a donor card; a National Donor Sabbath pendant; and several additional items embossed with the project name and logo. Participants in the program were 1.6 times more likely to have discussed, or be in discussion, with family members about their organ donation wishes than those who had not participated in the program.\textsuperscript{33} A revised program, Project ACTS II, was designed to improve uptake by testing the intervention in individual and group settings.\textsuperscript{34} Participants in the revised program who viewed the video in a group setting had a significantly greater increase in positive attitudes toward donation and beliefs than those who were given the video to view at home.\textsuperscript{34} It is thought that the group dynamic provided an opportunity for active contemplation of donation-related beliefs, attitudes, and the act of registration, and engaged people in a way that could not be attained by reviewing materials individually.\textsuperscript{34}
A church-based intervention targeted to Hispanics entailed a 45-60 minute educational program, created specifically for religious organizations, administered to participants in four Catholic churches whose membership was predominantly Hispanic. The program, led by a local organ procurement organization and conducted in both English and Spanish, included factual information about the need for organ and tissue transplantation, how the organ donation and allocation process serves such a need, and discussion of religious misconceptions regarding organ donation. After the intervention, significant increases in organ donation knowledge and positive perceptions regarding organ donation were observed. However, no change in intent to donate was observed. Interestingly, both before and after the intervention, those whose families supported organ donation were more likely to indicate intent to donate than those whose families did not support donation. The study authors therefore suggest that education focused on family support is important in improving intent to donate.

Other church-based education programs have not been successful. A peer-led program at predominantly African American churches, in which a church member was trained to provide educational sessions within the church, included the viewing of a video and discussions about organ donation and the provision of brochures and flyers containing the web address of the donor registry. No statistically significant differences in organ donation attitudes or intent to donate were observed following the intervention. The study concluded that lack of pastoral support may have influenced outcomes, and that participants misinterpreted the consent form to be involved in the study as an affirmative indication that they wished to be organ donors.

Community-Based Targeted Interventions

A 2007-2012 community-based intervention targeting Hispanics resulted in an increase in consent for organ donation. Media messages were conveyed on television and radio, and culturally sensitive educational programs were held at high schools, churches, and medical clinics in four Southern California neighborhoods with a high percentage of Hispanic residents. Among those targeted by the intervention, the consent rate for organ donation increased significantly from 56 percent before the intervention to 83 percent after the intervention.

A different approach has been to use peer-to-peer techniques to deliver health education messages. This technique was employed in several Michigan hair salons, with hair stylists acting as lay health advisors to improve organ donation among their African-American clients. Stylists delivering the intervention were asked to discuss organ donation at least twice with their clients. Following the intervention, clients in the intervention group were 1.7 times more likely than those in the control group (in which general health topics, but not organ donation specifically, were discussed) to report positive donation status.

CURRENT AMA POLICY

The AMA has a number of policies related to improving organ donation. Regarding education, AMA policy supports “state of the art” educational materials for the medical community and the public that address the importance of organ donation and the need for organ donors (H-370.995, H-370.996), development of effective methods for meaningful exchange of information to educate the public about donating organs (H-370.959), implementation of UNOS recommendations for organ donation (H-370.983), and the provision of educational materials by states and local organ procurement organizations to attendees of driver education and safety classes (H-370.984). AMA policy also encourages research on methods for increasing the number of organ donors in the United States, including studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation (H-370.959); studies evaluating the use of incentives,
including valuable considerations, to increase living and deceased organ donation rates (H-370.958); and pilot studies on promotional efforts that stimulate each adult to respond "yes" or "no" to the option of signing a donor card. Ethical Opinion 6.1.4, “Presumed Consent and Mandated Choice for Organs from Deceased Donors,” describes the ethical challenges of presumed consent and mandated choice models and emphasizes the need for education about organ donation.

CONCLUSIONS

Although the numbers of organ donors and transplants have grown over the last two decades, the need for donated organs still far exceeds the number available for transplantation. This disparity is especially true for certain racial and ethnic minorities that make up a larger proportion of the transplant waiting list compared to their relative proportion among organ donors. Educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates have been developed to improve donation. Some have been successful at improving knowledge about organ donation, comfort in discussing organ donation wishes with family members, and intent to donate; however, it is difficult to determine the impact of the programs on donation because they do not occur in isolation from other factors that may influence organ donation rates.

Non-targeted educational approaches have had success as well. For example, an organ donation registration campaign in California consisting of intense public awareness using public service announcements; news conferences; and community outreach in federal buildings, universities, and libraries; combined with an online organ donor registration process at the Department of Motor Vehicles, improved consent for donation from 47.5 percent before the campaign to 51 percent after the campaign.39 And direct mail campaigns, in which information about organ donation and a request to join the state organ donor registry are mailed to residents, have been successful in prompting both young adults and older adults to join organ donation registries.40,41

Additionally, other approaches to improving organ donation rates should be explored. A 2015 analysis examined a number of state policies on organ donation, including first-person consent laws, donor registries, dedicated revenue streams for donor recruitment activities, population education programs, paid leave for donation, and tax incentives, and found that only revenue policies to promote organ donation had any effect on organ donation and transplantation.27 These revenues can be used on funding for outreach campaigns and educational programs that incorporate elements that appear to be most successful in increasing intent to donate. Others have proposed that financial incentives in the form of a contribution to a donor’s retirement fund, an income tax credit, a tuition voucher, or a posthumous funeral benefit would be far more effective at increasing the donor pool than educational approaches.42

The Council on Science and Public Health supports continued implementation of targeted educational programs that have shown promise in increasing intent to donate, and encourages further study of other approaches that may be successful.
RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted and remainder of report filed.

1. That Policy H-370.959, “Methods to Increase the US Organ Donor Pool,” be amended by addition to read as follows:

   In order to encourage increased levels of organ donation in the United States, our American Medical Association: (1) supports studies that evaluate the effectiveness of mandated choice and presumed consent models for increasing organ donation; (2) urges development of effective methods for meaningful exchange of information to educate the public and support well-informed consent about donating organs, including educational programs that address identified factors influencing attitudes toward organ donation and targeted to populations with historically low organ donation rates; and (3) encourages continued study of ways to enhance the allocation of donated organs and tissues. (Modify Current HOD Policy)

2. That Policy D-370.984 be rescinded, having been accomplished through this report. (Rescind HOD Policy)

Fiscal note: Less than $1000
REFERENCES

23. Deedat S, Kenten C, Morgan M. What are effective approaches to increasing rates of organ donor
EXECUTIVE SUMMARY

Objective. This report considers whether neuropathic pain should be recognized as a distinct disease state.

Methods. English-language reports on studies using human subjects were selected from a MEDLINE search of the literature from 2005 to August 2017 using the search terms “neuropath*,” in combination with “pain,” and “pathophysiology,” “chronic,” and “pain as a disease.” A total of 103 articles were retrieved for analysis based on their ability to supply new information about the pathogenesis of chronic and neuropathic pain, as well as viewpoints on whether chronic (including neuropathic) pain can or should be considered as a disease in its own right. Medical dictionaries were consulted for definitions of disease and related terms.

Results. Understanding of the human pain experience has evolved over time. Although a detailed understanding of the neuroanatomy underlying the perception of noxious stimuli (nociception), exists, neuroimaging studies have identified several brain regions that are activated during the pain experience, dubbed the “pain matrix;” many of the same regions are also activated during various emotional and behavioral responses. Chronic pain is now recognized as an integrative sum of nociceptive input and factors related to cognition, mood, and context, as well as individual biologic, psychologic and social factors and various co-morbidities. Many “diseases” are accompanied by persistent pain, and chronic pain itself has been described by some as a disease. With respect to neuropathic pain, many different types of neural lesions and systemic diseases trigger neuropathic pain symptoms, which include various positive, negative, and evoked symptoms. Much of the thinking about chronic pain as a disease has been driven by the results of neuroimaging studies. Neuropathic pain also is characterized by adaptive cellular and functional changes which appear to persist after healing of the original injury. Based on neuroimaging, cross sectional studies of structural and functional changes accompanying chronic pain, including neuropathic pain, support clear differences compared with both normal conditions and the presence of acute nociceptive pain. It remains unclear what the cause and effect relationships might be, or whether such brain alterations should be viewed primarily as an adaptive response to continuing nociceptive input.

Conclusion. Evaluating neuropathic pain as a distinct disease state would be best deliberated by a group of multi-specialty experts involved in the evaluation and treatment of pain who could more deeply focus on the topic and consider all of its ramifications. At the 2016 Interim Meeting the House adopted a resolution directing the American Medical Association (AMA) to convene a Federation-based pain care task force (Policy D-160.922). This task force is in the process of being formed, and the Council believes that it is a more appropriate body to address this issue in a comprehensive manner.
Resolution 912-I-16, “Neuropathic Pain as a Disease,” introduced by the American Academy of Pain Medicine at the 2016 Interim Meeting and referred to the Board of Trustees, asked:

That our American Medical Association recognize neuropathic pain as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance neuropathic pain treatment and prevention.

**METHODS**

English-language reports on studies using human subjects were selected from a MEDLINE search of the literature from 2005 to August 2017 using the search terms “neuropath*,” in combination with “pain,” and “pathophysiology,” “chronic,” and “pain as a disease.” A total of 103 articles were retrieved for analysis based on their ability to supply new information about the pathogenesis of chronic and neuropathic pain, as well as viewpoints on whether chronic (including neuropathic) pain can or should be considered as a disease in its own right. Medical dictionaries were consulted for definitions of disease and related terms.

**BACKGROUND**

The Council previously examined the issue of neuropathic pain on two occasions. In 2005, the Council reviewed the neurobiology of nociceptive and neuropathic pain, and the definition, classification, common causes, diagnostic approach, and pharmacologic management of neuropathic pain.1 In 2010, the Council reviewed more recent findings about how neural damage, which is the signature precipitating event for the development of neuropathic pain, provokes multiple responses in nociceptive pathways that generate and amplify pain.2 Such responses include peripheral and central sensitization, ectopic activity in pain carrying fibers, neuronal cell death, disinhibition, altered gene expression, neuron sprouting, neuronal plasticity and modified neural connectivity.2 Some discussion was devoted to whether such changes, which can eventually persist in the absence of ongoing noxious stimuli, should be considered maladaptive and warrant consideration as a disease. The Council did not specifically endorse that viewpoint, concluding in part, that the clinical value of viewing chronic or neuropathic pain as a disease was not established. This report responds to the specific request that our AMA, through Council evaluation and deliberation by the House of Delegates, recognize neuropathic pain as a disease state. It is already established that neuropathic pain is characterized by “multiple pathophysiologic aspects” and requires a treatment approach that differs from that applied to chronic nociceptive and inflammatory pain.
RELEVANT DEFINITIONS

Pain
Pain is “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.” This definition acknowledges that pain is a conscious experience involving interpretation of (painful) sensory input that is influenced by emotional, pathological, and cognitive factors, as well as previous pain experiences.

Nociceptive Pain
Nociceptive pain is caused by tissue injury generating pain through the primary somatosensory nervous system via a process involving activation of peripheral nociceptors, transduction, transmission, modulation and perception of noxious stimuli. Nociceptive pain can be acute, subacute or chronic, may be complicated by inflammation, and may be visceral or referred in origin.

Chronic Pain
Chronic pain has been variously defined. The definition used by the Centers for Disease Control and Prevention in developing its guideline on the use of opioids in chronic noncancer pain is based on the International Association for the Study of Pain (IASP) definition: “Ongoing or recurrent pain, lasting beyond the usual course of acute illness or injury healing, more than 3 to 6 months, and which adversely affects the individual’s well-being.”

Neuropathic Pain
Neuropathic pain was re-defined by the IASP in 2012 as “pain initiated or caused by a lesion or disease of the somatosensory system.” The basis for this definition is that “neuropathic pain is not a single disease, but a syndrome caused by a range of different diseases and lesions, which manifests as an array of symptoms and signs.”

Disease
• An interruption, cessation, or disorder of body function, system, or organ OR a morbid entity characterized usually by at least two of these criteria: recognized etiologic agent(s), identifiable group of signs and symptoms, or consistent anatomic alterations.
• Any deviation from or interruption of the normal structure or function of any body part, organ, or system that is manifested by a characteristic set of symptoms and signs whose etiology, pathology, and prognosis may be known or unknown.

Syndrome
The aggregate of symptoms and signs associated with any morbid process, and constituting together the picture of the disease.

Disorder
An illness that disrupts normal physical or mental functions.

EVOLUTION OF PAIN THEORY
Initial investigation and understanding of pain focused on describing the specific somatosensory pathways involved in pain processing. Nociception is the perception of noxious stimuli and represents an alarm signal mediated by specialized primary afferent (sensory) neurons that respond to sufficiently intense thermal, mechanical, or chemical stimuli, transduce these stimuli into electrical activity, and transmit signals via well-defined pathways in the central nervous system. Cell bodies of the primary afferent neurons are located in dorsal root ganglia and the spinal sensory
nucleus of cranial nerve V; bifurcated axonal processes are distributed to the periphery for
detection, and to the spinal cord to transmit information centrally. Aδ fibers (thinly myelinated)
carry a well-localized “first” pain of sharp, pricking quality. C fibers (unmyelinated) carry a poorly
localized “second” pain of dull and persistent or burning quality. Muscle and deep tissue nociceptor
stimulation produce aching or cramping type pain. There are several sub-populations of primary
afferents that differ in their axon diameter, response to stimuli, neurophysiologic and
neurochemical characteristics and targets in the dorsal horn of the spinal cord. When local
inflammation ensues, certain features of the nociceptive response are modified and magnified to
aid healing and repair.

In the spinal cord, peripheral pain-carrying primary afferent terminals synapse on (second order)
neurons within the superficial lamina of the dorsal horn, which ascends to form the spinothalamic
tract and spinoreticular system. The former transmits information about acute pain (location,
intensity, quality) through the thalamus to the somatosensory cortex and the latter is involved with
autonomic and affective reactions to pain. The dorsal horn is not a simple relay station but is
subject to “gating” by local interneurons with inhibitory and excitatory influences, as well as
descending influences from the midbrain and higher centers.

Secondary spinal projection neurons transmit nociceptive information to brainstem regions,
including the rostral ventral medulla and periaqueductal gray (PAG); this information is further
modulated in the brainstem, relayed to the thalamus, and then transmitted to the cortex where it is
interpreted as pain. Several cortical regions are involved in pain processing, including the primary
somatosensory cortex, secondary somatosensory cortex, insular cortex, prefrontal cortex, and
motor cortex.

The Pain Matrix

Although a detailed understanding of the neuroanatomy of nociception exists, neuroimaging
studies have identified several brain regions that are activated during the “pain experience.” This
pattern of neural activation has been posited to represent an array of interrelated brain regions
integral to human pain perception and response or colloquially representing the “neurosignature of
pain.” An extensive neural network (dubbed the “pain matrix”) is accessed during the
processing of nociceptive input including the primary and secondary somatosensory, insular,
anterior cingulate, and prefrontal cortices and the thalamus; subcortical areas (e.g., brain stem,
PAG, hypothalamus, amygdala, hippocampus, and even the cerebellum) also are involved in the
pain experience. Thus, modulation of the primary nociceptive stimulus occurs within the spinal
cord where noxious stimuli are just part of the overall sensory input, in response to descending
neuronal influences, and at numerous supraspinal levels affecting the discriminative, emotional,
and cognitive aspects of pain.

Neuroimaging studies have shown that many brain regions activated by nociceptive stimuli also are
activated during various emotional and behavioral responses, and that non-nociceptive events or
inputs (e.g., loss of a loved one, social exclusion) can produce pain-like experiences. These
types of findings have informed a conceptual three-tiered hierarchical model of the human pain
experience based on nociception (1st tier), conscious perception subject to cognitive and attentional
modulation and the triggering of somatic reactions (perceptive-attentional, 2nd tier), and
consideration of how individual factors and characteristics (including psychological factors and
emotional context) influence pain and the memory of that experience (reappraisal-emotional, 3rd
tier). Brains regions involved in the second and thirds tiers can either inhibit or facilitate
nociception in a descending fashion.
The Biopsychosocial Model of Chronic Pain

Pain is an individual and subjective experience, recognized as an integrative sum of nociceptive input and factors related to cognition, mood, and context, as well as individual variables such as genetics and sex. Chronic pain and patient outcomes are influenced by individual biologic, psychologic and social factors and various common comorbidities (Figure 1). Brain regions involved in the pain matrix are involved in many other sensory, motor, cognitive, and emotional functions and a reciprocal relationship exists between chronic pain and mental health disorders. Neural pathways that involve pain, depression and anxiety overlap and likely have important biological interactions that are not well understood. Chronic pain induces disturbances in mood (reactive depression or anxiety), impaired coping (often with catastrophization), and other processes which can worsen pain and pain-related distress and lead to fear-avoidance behaviors. Pain patients also have much higher premorbid or comorbid psychosocial concerns, mental health disorders and cognitive distortions that influence the pain experience and drive pain-related distress. Individuals who observe other people’s suffering often experience a subjective enhancement of their own pain suffering. Thus, the pain experience is influenced by various cognitive, emotional, and environmental factors affecting brain function. Chronic pain is a multidimensional experience that, like other chronic conditions has multiple contributors, including psycho-behavioral ones. Effective management often demands a multidisciplinary assessment and treatment plan that identifies and addresses all the components of the individual’s pain experience.

IS CHRONIC (OR NEUROPATHIC) PAIN A DISEASE?

Many “diseases” are accompanied by persistent pain including cancer, human immunodeficiency virus infection, osteoarthritis/rheumatoid arthritis, lower back injury, headache, degenerative spine disease, fibromyalgia, diabetes, post-herpetic neuralgia, etc. However, when considering whether neuropathic pain is a disease, it is important to note that the question of whether chronic pain should be considered a disease is not a new concept.

In 2001, the IASP and the European Federation of IASP Chapters adopted the following declaration:

“Pain is a major healthcare problem worldwide. Although acute pain may reasonably be considered a symptom of disease or injury, chronic and recurrent pain is a specific healthcare problem, a disease in its own right.”

The landmark 2011 report by the Institute of Medicine on Relieving Pain in America concluded that:

Chronic pain can be a disease in itself. Chronic pain has a distinct pathology, causing changes throughout the nervous system that often worsen over time. It has significant psychological and cognitive correlates and can constitute a serious, separate disease entity.

In 2016 Vardeh et al noted:

The past few decades have witnessed a huge leap forward in our understanding of the mechanistic underpinnings of pain, in normal states where it helps protect from injury, and also in pathological states where pain evolves from a symptom reflecting tissue injury to become the disease itself.

Neuropathic Pain

With respect to neuropathic pain, many different types of neural lesions and systemic diseases trigger neuropathic pain symptoms (e.g., diabetes, post-herpetic neuralgia, radiculopathies, stroke,
spinal cord injury, chemotherapy, certain surgeries, alcohol misuse, vitamin deficiencies, heavy metal toxicity, and many other causes and triggers). Signs and symptoms characteristic of neuropathic pain include spontaneous “positive” (gain of function) signs (e.g., paresthesias, burning, shooting or shock-like pains), “negative” (loss of function) signs (e.g., numbness, weakness, hypoalgesia, decreased tendon reflexes) and certain stimulus-dependent or evoked signs (e.g., allodynia, hyperalgesia) (Figure 2). Diseases causing neuropathic pain vary substantially in terms of anatomical location and cause; depending on the cause, individual patients exhibit similar clinical characteristics, but not all symptoms that are commonly associated with neuropathic pain. Two prominent neuropathic pain symptoms across causes are allodynia (pain induced by normally innocuous stimuli) and hyperalgesia (increased pain in response to noxious stimuli) (see below).

Debate on Chronic Pain as a Disease

The field of pain medicine, the Institute of Medicine and some clinicians and researchers have proposed that chronic pain should be considered a disease; others continue to see pain primarily as a symptom of disease. Much of the thinking about chronic pain as a disease has been driven by neuroimaging studies, and structural/functional changes observed in animal models of chronic pain and/or neural injury. It has been proposed that because some unique changes accompany neural injury, chronic pain with a neuropathic component should be considered in a distinct fashion.

Neuroimaging. An extensive literature base exists on using various brain imaging techniques in patients with chronic pain, including neuropathic pain; most studies have been cross-sectional. A comprehensive review is beyond the scope of this report. A critical review of more than 100 brain neuroimaging reports identified neural correlates of chronic pain associated with various diseases (i.e., osteoarthritis, irritable bowel syndrome, back pain, fibromyalgia) and demonstrated distinctions from images associated with acute nociceptive pain. Patients suffering from chronic pain also exhibit dysfunction in descending inhibition of pain, less gray matter in the thalamus and prefrontal cortex with more gray matter loss in patients with neuropathic components; differences in various measures of brain neurochemistry also have been demonstrated. Subsequent studies extended these findings to other chronic pain conditions (pelvic pain, complex regional pain syndrome, diabetic peripheral neuropathy, phantom limb pain) demonstrating changes in gray matter density in multiple cortical regions, as well as the amygdala and hippocampus. What remains unresolved is to what extent altered structure, function and neurochemistry represents a “disease” or are simply neuroplastic adaptive processes in response to ongoing nociceptive input, or reflect the consequences of pain, common co-morbid conditions, medications, or altered lifestyles in patients with chronic pain.

Cellular and Functional Changes. Adaptive and persistent cellular and functional modifications also have been used to support the concept that neuropathic pain, in particular, is a chronic disease. As described in the previous Council report, neural injury provokes a host of neuroplastic and neuroimmune responses which become drivers of neuropathic pain, some of which also are common to persistent nociceptive/inflammatory pain. These include:

- peripheral sensitization of nociceptors related to altered trafficking of ion channels. Peripheral sensitization decreases the threshold for activation and augments normally painful stimuli (primary hyperalgesia) and triggers the development of spontaneous (ectopic) activity in primary afferent neurons;
- central sensitization, characterized by increased spontaneous activity, expansion of receptive fields, and a decreased threshold to primary afferent inputs into the dorsal horn. This ultimately enhances the function of neurons and circuits in nociceptive pathways via
increased membrane excitability, increased synaptic efficacy, and reduced inhibition. It manifests as mechanical allodynia and secondary hyperalgesia;

- changes in the phenotype of low threshold sensory fibers (Aβ) that are normally activated by touch, pressure, and vibration, to one whereby they can generate sensations of pain or tenderness;
- a pathological triad of reciprocal interactions among neurons, immune cells, and glial cells with glia activation and release of proinflammatory mediators that contributes to both peripheral and central sensitization; and
- disinhibition resulting from an imbalance of excitatory and inhibitory influences at the spinal cord level, and descending facilitation from the brain stem and higher centers.

DISCUSSION AND COMMENT

Recognition of chronic pain as a disease may lead to increases in resources, education, and priority, but considerable attention has already been devoted to the burden of chronic pain in the United States, and a National Pain Strategy has been developed.

A disease, by definition, requires a set of “characteristic signs and symptoms.” Chronic pain is:

- complex, affecting individuals physically, mentally, socially and spiritually. This results in a common symptomatic and functional spectrum of physical, cognitive, psychological and behavioral effects. Decreased physical functioning coupled with little hope for effective treatment often results in a downward spiral of depression, distress, anxiety, and sleep problems, which lead to impaired social functioning and family relationship that all increase perceived pain.

Some of these consequences may be explained by common neural substrates or reciprocal interactions and may not be considered unique to chronic pain because they can accompany any chronic condition that causes substantial distress.

With neural injury or repetitive nociceptive stimuli, remodeling of the nervous system and alteration in gene expression occurs. Such changes reflect neuroplasticity that impacts pain in the peripheral and central nervous system, leading to increased excitability within pain circuits and generating peripheral and central sensitization, which underlie the phenomena of hyperalgesia, allodynia, and the spread of pain to adjacent uninjured regions (secondary hyperalgesia). Based on neuroimaging research, cross sectional studies of structural and functional changes accompanying chronic pain, including neuropathic pain, support clear differences compared with both normal conditions and the presence of acute nociceptive pain, but it remains unclear what the cause and effect relationships might be, or whether such brain alterations should be viewed primarily as an adaptive response to continuing nociceptive input. Do these phenomena fulfill the requirement for the presence of “characteristic signs and symptoms?” Does it make sense to consider an altered pain response as a symptom that can logically define pain as a disease?

With respect to pain management and relieving the burden of suffering among patients with chronic pain, it would seem that wider adoption of the biopsychosocial model of pain management should be the most important goal, with attention to reducing pain, restoring function, cultivating well-being and improving quality of life. This requires identifying and addressing psychosocial contributors and emphasizing active over passive modalities. For neuropathic pain, diagnostic and management approaches are different; preferred initial pharmacological interventions are antiepileptic and antidepressant drugs. Several interventional approaches are available but psychobehavioral approaches can be more challenging in patients with neural injury.
CONCLUSION

The topic of neuropathic pain as disease would be best deliberated by a multi-specialty group of experts involved in the evaluation and treatment of pain that could more deeply focus on the topic and consider all of its ramifications. At the 2016 Interim Meeting the House of Delegates adopted a resolution directing the AMA to convene a Federation-based pain care task force (Policy D-160.922). This task force is in the process of being formed and the Council believes that it is a more appropriate body to address this issue in a comprehensive manner.

RECOMMENDATION

The Council on Science and Public Health recommends that the following statement be adopted in lieu of Resolution 912-I-16 and the remainder of this report be filed:

That the Federation Task Force on Pain Care evaluate the relative merits of declaring neuropathic pain as a distinct disease state, and provide a recommendation to the Council on Science and Public Health. (Directive to Take Action)

Fiscal Note: Less than $500
REFERENCES


Figure 1. Biopsychosocial Context of Pain

- Physiologic Stimulus
  - Neuropathic/Nociceptive

- Individual Biopsychosocial Context
  - Life Experiences
  - Environmental Stressors
  - Work History
  - Family/Friends
  - Dynamics & Support
  - Culture
  - Self-Efficacy
  - Coping
  - Acceptance
  - Suffering

- Experience of Pain

- Quality of Life
  - Health Status
  - Conditioning
  - Functioning
  - Cognition
  - Mood
  - Substance Use
  - Sleep
  - Biogenetics
Figure 2. Signs and Symptoms Characteristic of Neuropathic Pain

Neuropathic Pain

Positive Signs
- “Paresthesias ("Tingling", "Pins and Needles")
- “Burning” or “Hot”

Stimulus-dependent Evoked
- Allodynia
- Hyperalgesia
- Hyperpathia

Negative Signs
- Numbness
- Weakness
- Hypoesthesia
- Hypoalgesia
- ↓Tendon reflexes
Subject: National Drug Shortages: Update

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

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

INTRODUCTION

Policy H-100.956, “National Drug Shortages,” directs the Council on Science and Public Health (CSAPH) to continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates (HOD) on progress made in addressing drug shortages in the United States. This informational report provides an update on continuing trends in national drug shortages and ongoing efforts to further evaluate and address this critical public health issue.

METHODS

English-language reports were selected from a PubMed and Google Scholar search from September 2016 to August 2017, using the text term “drug shortages” combined with “impact,” “crisis,” “oncology,” “chemotherapy,” “antibacterial,” “pediatric(s),” “nutrition,” and “parenteral.” Additional articles were identified by manual review of the references cited in these publications. Further information was obtained from the Internet sites of the US Food and Drug Administration (FDA), American Society of Health-System Pharmacists (ASHP), Pew Charitable Trusts, the Association for Accessible Medicines, the Pharmaceutical and Research Manufacturers of America (PhRMA) and by direct contact with key FDA, ASHP, and Utah Drug Information Service staff who monitor drug shortages and related issues on a daily basis.

BACKGROUND

The Council has issued seven reports on drug shortages. The findings and conclusions of the first five reports are summarized in CSAPH Report 2-I-15. The remainder of this report will update information on drug shortages since the 2016 report was developed.

CURRENT TRENDS IN DRUG SHORTAGES

The two primary data sources for information on drug shortages in the United States continue to be the Drug Shortage Resource Center maintained by ASHP in cooperation with the University of Utah Drug Information Service and the Drug Shortage Program at the FDA. Table 1 summarizes how the ASHP’s and FDA’s information and statistics on drug shortages are developed. The ASHP defines a drug shortage as “a supply issue that affects how the pharmacy prepares or dispenses a drug product or influences patient care when prescribers must use an alternative agent.” The FDA defines shortages as “a period of time when the demand or projected demand for a medically necessary drug in the United States exceeds its supply.” Medically necessary drugs are...
defined by FDA as “any drug product used to diagnose, treat, or prevent a serious disease or medical condition for which there is no other drug that is judged to be an appropriate substitute or there is an inadequate supply of an acceptable alternative.”

Because their criteria differ (the main distinction being the FDA’s definition of a “medically necessary drug”), the ASHP site lists more drug shortages than the FDA site.

*American Society of Health-System Pharmacists*

As of August 7, 2017, ASHP’s Drug Shortage Resource Center identified 133 drugs in shortage, approximately the same number as at the corresponding time in 2016 (135). In addition, 14 products are not commercially available at all. Seventy-one manufactured drugs have been discontinued since 2010, an increase of two from a year ago. Nearly 85% of drug shortages are generic sterile injectable formulations. The top active shortages by drug class remain antimicrobials, electrolytes and nutritional components, central nervous system agents, chemotherapeutic agents and cardiovascular/autonomic drugs. For a longitudinal view of new drug shortages on an annual basis, and the number of active drug shortages quarterly, see the Appendix. Active shortages include both new and unresolved drug shortages. According to ASHP, the number of new shortages is currently on a par with 2016, and the number of active shortages has stabilized.

*US Food and Drug Administration*

As of August 7, 2017, the FDA reported that 46 drugs were currently in shortage (compared with 61 one year ago), and 13 other shortages had been resolved. The latter are closely monitored because they may be at risk for falling back into shortage. Based on passage of the Food and Drug Administration Safety and Innovation Act (FDASIA) in 2012, companies are required to notify the FDA of a permanent discontinuance or an interruption in manufacturing of certain drug products six months in advance, or if that is not possible, as soon as practicable. The shortage notification requirement has apparently reduced the number of new shortages by allowing FDA additional time to work with manufacturers to prevent shortages. The FDA’s drug shortages website lists drugs that meet these criteria, reflecting shortage information supplied by manufacturers. A Final Rule published on July 27, 2015, provides further guidance on the notification process and adds biologic products to the requirements for notification about potential supply disruptions.

**Drug Shortages Metrics Reported by FDA.** The FDA’s fourth annual report on drug shortages (required by FDASIA) noted the following metrics during the first three quarters of calendar year 2016:

- FDA was notified of 186 potential shortage situations by 67 different manufacturers, a 35% increase over the number of potential shortages reported in 2015.
- 64 new drug shortages were prevented in the first three quarters of 2016, a 50% decrease over the comparable time period for 2015.
- The review of 102 generic abbreviated new drug or supplemental applications was expedited, exactly the same as the number reported in 2015.
- 10 inspections were prioritized to address a drug shortage, comparable to the number reported in 2015.
- Three fewer new drug shortages occurred in 2016 (23) compared with 2015 (26); currently, FDA is working to resolve 24 ongoing shortages that began prior to 2016, which is a decrease from the 64 ongoing shortages tracked at the end of 2015 (Personal Communication, Valerie Jensen, RPh, FDA).
• FDA exercised regulatory flexibility and discretion in 25 instances affecting 15 medically necessary products. Most of these involved measures to mitigate risks such as the use of filters to remove particulate matter, extra testing for quality, third-party oversight of production, provision of special instructions to prescribers and/or patients, approval of foreign sources, and expanded access to investigational drugs for treatment use. With respect to approval of new foreign sources, the FDA now conducts regular virtual meetings with their international regulatory counterparts to share information on drug shortages and mitigation strategies impacting patients in other countries.

The FDA continues its work to improve its system for data tracking and drug shortage analysis. The FDA released a new technology platform in 2017 for drug manufacturers/applicants to send drug shortage and supply notifications. The “Direct NextGen” platform allows users to login, enter their shortage information, and submit to the FDA. This approach is intended to “streamline day-to-day work to identify and mitigate shortages, including research, data entry, and data management.”

The FDA also has developed apps for both the iPhone and Android operating systems that provide access to drug shortage information as well as notifications about new and resolved drug shortages. Physicians can directly report a drug shortage via the app, the ASHP drug shortage website, or to the Center for Drug Evaluation and Research via email (drugshortages@fda.hhs.gov) or by phone at 240-402-7770.

In late June 2017, the FDA took additional steps to increase competition in the market for prescription drugs and facilitate entry of lower-cost alternatives. The agency published a list of off-patent, off-exclusivity branded drugs without approved generics, and also implemented, for the first time, a new policy to expedite the review of generic drug applications where competition is limited.

STATE OF THE INDUSTRY

Report from Pew Charitable Trusts

Potential economic drivers of drug shortages were previously evaluated by the Council. A new report from Pew Charitable Trusts and the International Society for Pharmaceutical Engineering took a closer look at shortages of sterile injectable pharmaceutical products based on interviews with company executives; the main focus areas were market forces, business continuity planning, and supply chain management.

The report confirmed that quality issues continue to be a driving force behind shortages. Examples included FDA-inspection-related delays, delays in active pharmaceutical ingredient acquisition, failure of final product quality to meet good manufacturing practices, and problems arising from transferring the product from development (or in transferring new technology for a legacy product) to commercial manufacturing site. Factors cited by companies that contributed to drug shortages other than quality included market withdrawals, supply chain design, lack of business continuity elements needed to protect against shortages, limited purchaser-manufacturer incentives, limited insight into future market demands, and regulatory challenges impacting facility expansion or upgrading equipment; the latter is especially pertinent for legacy products.
CURRENT PERSPECTIVE

Based on analysis by the Utah Drug Information Service, during the past 2 years, the number of new drug shortages affecting clinicians and patients has been declining, and the number of active and ongoing drug shortages has remained similar (Appendix, Personal Communication, Erin Fox, PharmD). Shortages have stabilized, but even though the number remains elevated, it is significantly lower than 3 to 4 years ago. The fact that a high number of shortages continues to exist has obscured to a certain degree the progress that has been made, largely attributable to manufacturer notification requirements and proactive steps taken by the FDA. These changes have substantially decreased the actual number of shortages by preventing a large number of new ones. Significant progress has been made overall, but this progress has remained largely unnoticed by hospital pharmacists and practicing physicians who continue to experience the effects of ongoing shortages on a daily basis.

Additionally, it is apparent that some difficult challenges to continued progress exist. As previously noted, most drug shortages involve generic sterile injectable formulations and the cause of these shortages is typically manufacturing and quality problems. The 2016 report from the Government Accountability Office (discussed in the 2016 Council report) identified a decline in the number of suppliers, failure of a supplier to comply with manufacturing standards resulting in a warning letter, and manufacturers operating at low profit margins for generic drugs as primary contributing factors. A major contributing factor to this trend was the failure of Boehringer Ingelheim’s BenVenue manufacturing facility in Bedford, Ohio, in 2013, which at the time was one of the largest suppliers of sterile injectable drugs, including many cancer chemotherapy products. The failure occurred despite the investment of $350 million to upgrade the facility; facing projected deficits of at least $750 million, the facility was not profitable and was closed.

Currently, the majority of sterile injectables for the US market are produced by Pfizer (Hospira), Fresenius Kabi (Akorn), Teva and Baxter; other contributors are American Regent (Luitpold), Sandoz, and Mylan. Pfizer completed its acquisition of Hospira, at the time the largest manufacturer of sterile injectable in the United States, in September 2015. Recent events have created a climate of worsening drug shortages for critical care and emergency medications as well as some of what would be considered “basic products” emanating from the Hospira portfolio. In April 2017, Pfizer notified clinicians about a shortage of pre-packaged emergency drug syringes including atropine, dextrose, epinephrine, and sodium bicarbonate. In June, Pfizer recalled 42 lots of sodium bicarbonate vials (approximately half of supplies) due to concerns that the product may not be sterile; succinylcholine was also impacted by this recall. Most recently, Pfizer had to halt production of 30 different Carpuject™ products (morphine, hydromorphone, etc.) due to problems at a specific manufacturing facility. Vial substitutes exist for most of the Carpuject™ products, but there may be shortages later this year. In response, the FDA extended expiration dating for emergency syringes, approved another supplier of sodium bicarbonate, and also allowed imported sodium bicarbonate.

Although attention remains focused on injectable products, shortages of some solid dosage forms, including atenolol, furosemide, and methylphenidate tablets also have created problems for clinical management this year.

CONCLUSION

The generic sterile injectable drug industry is fragile and some drug supplies for acutely and critically ill patients in the United States remain vulnerable despite industry and federal efforts. Until new and reliable production capacity for sterile injectables is developed, the situation will not
appreciably improve. Some progress is being made, but permanent solutions remain elusive and beyond the control of individual practitioners and the health care system. As long as a free market economy exists and no one entity, including the FDA can mandate that a company produce a specific product, drug shortages will exist into the foreseeable future as the industry continues to merge and contract (except for high cost specialty drugs), the number of drugs emerging off patent increases each year, and the profit margin for legacy products disappears. This dynamic is occurring at the same time that pharmaceutical companies are under increasing pressure to reduce drug costs. The recent acquisition of Hospira by Pfizer and the resulting shortages raises the issue of how such acquisitions or mergers might impact the likelihood of such shortages.

RECOMMENDATION

The Council recommends that Policy H-100.956 be amended by addition to read as follows:

National Drug Shortages

1. Our AMA supports recommendations that have been developed by multiple stakeholders to improve manufacturing quality systems, identify efficiencies in regulatory review that can mitigate drug shortages, and explore measures designed to drive greater investment in production capacity for products that experience drug shortages, and will work in a collaborative fashion with these and other stakeholders to implement these recommendations in an urgent fashion.

2. Our AMA supports authorizing the Secretary of Health and Human Services to expedite facility inspections and the review of manufacturing changes, drug applications and supplements that would help mitigate or prevent a drug shortage.

3. Our AMA will advocate that the US Food and Drug Administration (FDA) and/or Congress require drug manufacturers to establish a plan for continuity of supply of vital and life-sustaining medications and vaccines to avoid production shortages whenever possible. This plan should include establishing the necessary resiliency and redundancy in manufacturing capability to minimize disruptions of supplies in foreseeable circumstances including the possibility of a disaster affecting a plant.

4. The Council on Science and Public Health shall continue to evaluate the drug shortage issue and report back at least annually to the House of Delegates on progress made in addressing drug shortages.

5. Our AMA urges the development of a comprehensive independent report on the root causes of drug shortages. Such an analysis should consider federal actions, the number of manufacturers, economic factors including federal reimbursement practices, as well as contracting practices by market participants on competition, access to drugs, and pricing. In particular, further transparent analysis of economic drivers is warranted. The Centers for Medicare & Medicaid Services should review and evaluate its 2003 Medicare reimbursement formula of average sales price plus 6% for unintended consequences including serving as a root cause of drug shortages.

6. Our AMA urges regulatory relief designed to improve the availability of prescription drugs by ensuring that such products are not removed from the market due to compliance issues unless such removal is clearly required for significant and obvious safety reasons.

7. Our AMA supports the view that wholesalers should routinely institute an allocation system that attempts to fairly distribute drugs in short supply based on remaining inventory and considering the customer's purchase history.

8. Our AMA will collaborate with medical specialty partners in identifying and supporting legislative remedies to allow for more reasonable and sustainable payment rates for prescription drugs.
9. Our AMA urges that during the evaluation of potential mergers and acquisitions involving pharmaceutical manufacturers, the Federal Trade Commission consult with the FDA to determine whether such an activity has the potential to worsen drug shortages. (Modify Current HOD Policy)

Fiscal Note: Less than $500
REFERENCES

Table 1. Contrasting the FDA (CDER) and ASHP Drug Shortage Websites

<table>
<thead>
<tr>
<th></th>
<th>FDA</th>
<th>ASHP</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Provides information obtained from manufacturers about current shortages, estimated duration, and discontinuations and provides information about FDA’s and other stakeholders’ roles in addressing and preventing shortages</td>
<td>Notification of new shortages and status of ongoing shortages; drug shortage management resources</td>
</tr>
<tr>
<td><strong>Audience</strong></td>
<td>Public</td>
<td>Healthcare practitioners</td>
</tr>
<tr>
<td><strong>Scope of shortage list</strong></td>
<td>All drugs are listed that are confirmed to be a national shortage by FDA. A shortage is considered to be the period of time when the demand for the drug within the United States exceeds the supply of the drug.(^a)</td>
<td>All drug and biologic shortages reported and confirmed with manufacturer that are national in impact.</td>
</tr>
<tr>
<td><strong>Source of shortage report</strong></td>
<td>Manufacturers notify FDA of production disruption and voluntarily provide updates. Reports are also received from ASHP and from public via <a href="mailto:drugshortages@ceder.fda.gov">drugshortages@ceder.fda.gov</a> Note: Manufacturer-provided information represents shortage status at drug firm level.</td>
<td>Voluntary reports from practitioners, patients, pharmaceutical industry representatives and others Note 1: Information is updated based on release dates from manufacturers. Note 2: Reports reflect status at healthcare provider level.</td>
</tr>
<tr>
<td><strong>Criteria for inclusion on list</strong></td>
<td>Manufacturers cannot meet current market demand for the drug based on information provided by manufacturers and market sales research. Drug listed are defined as “medically necessary.”</td>
<td>(1) Shortage is verified with manufacturers and (2) affects how pharmacy prepares or dispenses a product, or (3) requires use of alternative drugs, which may affect patient care.</td>
</tr>
<tr>
<td><strong>Criteria for resolving shortage</strong></td>
<td>One or more manufacturers are in production and able to meet full market demand.</td>
<td>All manufacturers of the drug restore all formulations and dosage sizes to full availability. Note: Products are listed despite partial or restricted availability as supply chain disruptions can result in intermittent shortages at the provider or patient level.</td>
</tr>
<tr>
<td><strong>Reason for shortage</strong></td>
<td>Provided by manufacturers using reasons required by legislation.(^b) FDA encourages firms to provide additional information about reasons and other information which, if proprietary, is nondisclosable without the firm’s permission.</td>
<td>Provided by manufacturer, if willing to disclose. Note: May differ from FDA’s due to different sources of information and legislation requiring FDA to use specified reasons</td>
</tr>
<tr>
<td><strong>Other information</strong></td>
<td>Estimated duration, links to regulatory information such as recalls and Dear Healthcare Provider Letters</td>
<td>Estimated duration, list of available products, implications for patient care and safety, shortage management strategies, therapeutic alternatives</td>
</tr>
</tbody>
</table>

\(^a\) Note: A separate shortage webpage for vaccines and some biologics is maintained by the Center for Biologics Evaluation and Research.

\(^b\) Categories include (a) requirement related to complying with good manufacturing practices; (b) regulatory delay; (c) shortage of an active ingredient
APPENDIX

National Drug Shortages
New Shortages by Year
January 2001 to June 30, 2017

Note: Each column represents the number of new shortages identified during that year.
University of Utah Drug Information Service
Frin.Fox@hsc.utah.edu, @foxer1n

National Drug Shortages –
Active Shortages by Quarter

Note: Each column represents the number of active shortages at the end of each quarter.
University of Utah Drug Information Service
Frin.Fox@hsc.utah.edu, @foxer1n
Whereas, Increased screen time amongst youth has been associated with an increase in
morbidities such as obesity, sleep problems, depression and anxiety\(^1\); and
Whereas, Screen time can be utilized for both educational and recreational purposes; and
Whereas, Screens with artificial light, as found in smart phones and tablets, can emit a
substantial amount of short-wavelength (blue-enriched) light emissions\(^2\); and
Whereas, The blue light emitted from screens can lead to disruption of circadian rhythm, as it
suppresses melatonin secretion, and enhances alertness which can ultimately impact duration
and quality of sleep\(^2,3\); therefore be it
RESOLVED, That our American Medical Association encourage all schools to incorporate into
health class curriculum the topic of balancing screen time with physical activity and sleep (New
HOD Policy); and be it further
RESOLVED, That the AMA encourage research into the utility of blue light filtering glasses and
a blue light filter option on devices such as smart phones and tablets (New HOD Policy); and be
it further
RESOLVED, That our AMA encourage physicians to assess all patients and educate all parents
about amount of screen time, physical activity and sleep habits. (New HOD Policy)

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

Received: 09/06/17

References:
\(^1\) https://www.ncbi.nlm.nih.gov/pubmed/28168778
\(^2\) http://www.health.harvard.edu/staying-healthy/blue-light-has-a-dark-side
\(^3\) http://journal.frontiersin.org/article/10.3389/fpubh.2015.00233/full

RELEVANT AMA POLICY
Human and Environmental Effects of Light Emitting Diode (LED) Community Lighting H-135.927
1. Our AMA supports the proper conversion to community-based Light Emitting Diode (LED) lighting, which
reduces energy consumption and decreases the use of fossil fuels.
2. Our AMA encourages minimizing and controlling blue-rich environmental lighting by using the lowest
emission of blue light possible to reduce glare.
3. Our AMA encourages the use of 3000K or lower lighting for outdoor installations such as roadways. All LED
lighting should be properly shielded to minimize glare and detrimental human and environmental effects, and
consideration should be given to utilize the ability of LED lighting to be dimmed for off-peak time periods.
(CSAPH Rep. 02, A-16)
Whereas, Trichomoniasis is the most common curable sexually transmitted infection (STI) in the United States according to the Centers for Disease Control and Prevention (CDC) and the most common non-viral sexually transmitted infection (STI) in the world according to the World Health Organization, with a rate of reinfection increasing to 31% among women treated for Trichomonas vaginalis; and

Whereas, Trichomoniasis is not a reportable STI and “partner notification programmes are not available in most clinic settings”; and

Whereas, The most recent CDC 2015 STD treatment guidelines state, “concurrent treatment of all sex partners is critical for symptomatic relief, microbiologic cure, and prevention of transmission and reinfections, […] EPT might have a role in partner management for Trichomoniasis and can be used in states where permissible by law”; and

Whereas, Metronidazole is an effective, curative, easy, and safe treatment for Trichomonas vaginalis with recommended regimens yielding cure rates of approximately 84%–98%, and expedited partner therapy has been shown to decrease rates of reinfection; and

Whereas, Current AMA policy already supports state legislation that permits physicians to provide partner therapy for gonorrhea and/or chlamydia infections, both of which are less common than Trichomoniasis (AMA Policy H-440.868); and

Whereas, Expedited partner therapy potentially abrogates the standard informed consent process (Ethical Opinion E-8.9, “Expedited Partner Therapy”), and appropriate use of this therapy ultimately improves public health through management of sexually transmitted diseases; therefore be it


7 CDC. Sexually Transmitted Diseases Treatment Guidelines, 2015. MMWR, 64(RR-03):1-137. [https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6403a1.htm](https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6403a1.htm)

RESOLVED, That our American Medical Association amend policy H-440.868 by addition and deletion to read as follows:

H-440.868 Expedited Partner Therapy
Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea, and/or chlamydia, and/or Trichomoniasis infection. (Modify Current HOD Policy)

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

Received: 09/12/17

RELEVANT AMA POLICY

H-440.868 Expedited Partner Therapy
Our AMA supports state legislation that permits physicians to provide expedited partner therapy to patients diagnosed with gonorrhea and/or chlamydia infection. Citation: Sub. Res. 928, I-07 Reaffirmed: CSAPH Rep. 01, A-17

H-440.979 Control of Sexually Transmitted Infections
The AMA urges increased efforts at all levels of organized medicine to bring sexually transmitted infections under control, through professional and public education, and support of the efforts of state Departments of Health, the Centers for Disease Control and Prevention, the National Institutes of Health, and other appropriate organizations. Citation: Res. 84, A-84 Reaffirmed by CLRPD Rep. 3 - I-94 Reaffirmation A-99 Modified and Reaffirmed: CSAPH Rep. 1, A-09 Reaffirmation A-10

See also: H-440.983 Update on Sexually Transmitted Infections; H-440.996 Sexually Transmitted Disease Control; E-8.9 Expedited Partner Therapy
Whereas, Nearly 3 in 10 women and 1 in 10 men in America have experienced some form of intimate partner violence, including rape, physical violence, and/or stalking;¹ and

Whereas, Victims of violence by an intimate partner report issues such as fearing injury, the perpetrator limiting the victim’s access to money or social support, or needing resources such as medical care, legal services, housing services, victim’s advocate services, and/or crisis hotlines;¹ and

Whereas, Our AMA has not updated its Diagnostic and Treatment Guidelines on Domestic Violence since 1992, and since, research has shown that relationship violence in couples involving a transgender or otherwise identifying individual present unique circumstances²; and

Whereas, Violence against LGBT individuals, including domestic violence, is underreported and at times falsely attributed to other kinds of violence like hate crimes;³,⁴ and

Whereas, Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Others (LGTQ+) individuals who are victims of domestic violence may have an added pressure of staying in the relationship and/or seeking treatment out of fear of being outed to family members, friends, or employers;⁵,⁶,⁷ and

Whereas, Some transgender individuals may be pressured to stay in an abusive relationship due to their partner’s threats of limiting access to sex replacement hormones or otherwise exploiting their vulnerabilities with gender transitioning;⁸,⁹ and

Whereas, Some transgender victims of domestic violence avoid reporting their abuse or seeking treatment because they do not want to add to stigma against the transgender community; and

Whereas, Our AMA has committed to address health disparities in LGBT populations and has committed to address family and intimate partner violence (AMA Policies H-65.976, H-515.965); and

Whereas, The term Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Others (LGBTQ+) is an umbrella term for individuals whose gender identities and sexual orientations differ from those who are cisgender and heterosexual, and should be considered as an effort to be more inclusive than other acronyms like LGB, LGBT, etc. which may be present in some research throughout this resolution; therefore be it

RESOLVED, That our American Medical Association publish an update to its 1992 Diagnostic and Treatment Guidelines on Domestic Violence to reflect recent data and to address unique issues faced by the LGBTQ+ population (Directive to Take Action); and be it further

RESOLVED, That our AMA promote crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence (New HOD Policy); and be it further

RESOLVED, That our AMA amend AMA Policy H-65.976 by addition to read as follows:

Nondiscriminatory Policy for the Health Care Needs of LGBTQ+ Populations H-65.976
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, healthcare workers, or employees to include "sexual orientation, sex, or gender identity" in any nondiscrimination statement (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend AMA policy H-160.991 by addition and deletion to read as follows:

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ+) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBTQ+; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ+ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ+ patients; (iii) encouraging the development of educational programs in LGBTQ+ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ+ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ+ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ+ patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding:
   (i) the need for women who have sex with women to undergo regular cancer and sexually
   transmitted infection screenings due to their comparable or elevated risk for these
   conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases
   in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for
   sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or
   gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals)
   experience intimate partner violence, and how sexual and gender minorities present with
   intimate partner violence differs from their cisgender, heterosexual peers and may have
   unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to
   increase physician competency on LGBTQ+ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations,
   focusing on issues of mutual concern in order to provide the most comprehensive and up-to-
   date education and information to enable the provision of high quality and culturally
   competent care to LGBTQ+ people. (Modify Current HOD Policy)

Fiscal Note: Estimated cost of $85,500 to implement resolution.

Received: 09/12/17

RELEVANT AMA POLICY

Education of Medical Students and Residents about Domestic Violence Screening H-295.912
Family and Intimate Partner Violence H-515.965
Nondiscriminatory Policy for the Health Care Needs of LGBT Populations H-65.976
Whereas, Cervical cancer screening is indicated for female-to-male transgender patients who have a cervix and are sexually active, according to general cervical screening guidelines;¹ and

Whereas, Routine cervical screening has been shown to greatly reduce both the incidence of new cervical cancers diagnosed each year and deaths from the disease;²,³, ⁴ and

Whereas, Some health care providers employ a misconception that female-to-male transgender patients have a lower risk of cervical cancer;⁵ and

Whereas, A recent survey of obstetricians and gynecologists found that only 29% were comfortable caring for female-to-male transgender patients;⁶ and

Whereas, Female-to-male transgender patients are significantly less likely to be up to date on Pap smears than cisgender women;⁷ and

Whereas, Female-to-male transgender patients face barriers to adequate cervical cancer screening, including lack of access to safe and inclusive health care providers and lack of education on the importance of continuing to receive Pap smears as compared to cisgender patients facing cervical cancer screenings;⁸,⁹,¹⁰,¹¹ and

Whereas, Even when receiving Pap smears, female-to-male transgender patients are significantly more likely to have longer periods to test follow up from ambiguous lab results than non-transgender patients; therefore be it

RESOLVED, That our American Medical Association amend Policy H-160.991[2] by addition to read as follows:

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women and female-to-male transgender patients when medically indicated to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.

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

Received: 09/12/17

RELEVANT AMA POLICY

Health Care Needs of Lesbian Gay Bisexual and Transgender Populations H-160.991

1. Our AMA: (a) believes that the physician’s nonjudgmental recognition of patients’ sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of “reparative” or “conversion” therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.


See also: HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
WHEREAS, 71% of American teenagers use Facebook, 52% use Instagram, 41% use Snapchat, 24% of teens “go online almost constantly”, and 92% go online every day;¹ and

WHEREAS, 68% of all US adults use Facebook, with 76% of them saying they check it daily;² and

WHEREAS, Several recent studies indicate a link between increased use of social media and higher levels of anxiety and depression;³,⁴,⁵,⁶ and

WHEREAS, The American Academy of Pediatrics recognizes depression that develops when preteens and teens spend a great deal of time on social media sites, and advises parents to talk to their children and adolescents about their online use;⁷ and

WHEREAS, There are school-based mental health programs that have evidence of positive impact across a range of emotional and behavioral problems; however, there are few programs that address the association between social media usage and negative mental health sequelae;⁸,⁹ therefore be it

RESOLVED, That our American Medical Association collaborate with relevant professional organizations to (a) develop continuing education programs to enhance physicians’ knowledge of the health impacts of social media usage, and (b) develop effective clinical tools and protocols for the identification, treatment, and referral of children, adolescents, and adults at risk for and experiencing mental health sequelae of social media usage (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for schools to provide safe and effective educational programs by which students can learn to identify and mitigate the onset of mental health sequelae of social media usage. (New HOD Policy)

Fiscal Note: Estimated cost to implement resolution is $375,000.

Received: 09/12/17

RELEVANT AMA POLICY

Reduction of Online Bullying H-515.959

Internet Pornography: Protecting Children and Youth Who Use the Internet and Social Media H-60.934

Bullying Behaviors Among Children and Adolescents H-60.943

Providing Medical Services through School-Based Health Programs H-60.991

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

Increasing Detection of Mental Illness and Encouraging Education D-345.994
Whereas, Neonatal Abstinence Syndrome (NAS) is defined as a group of health problems seen in newborns exposed to addictive opiate drugs in utero, including dependency of the newborn; and

Whereas, The National Institute on Drug Abuse found that the average hospital stay for an infant born with NAS is 16.9 days as opposed to the 2.1 day average of non NAS infants, leading to an extra $1.5 billion in hospital expenses in the year 2012, which is a five-fold increase from 2000 to 2012; and

Whereas, Methadone and buprenorphine have been found to be effective and safe opioid maintenance therapies in pregnant and breastfeeding women; with negligible amounts of methadone transmission in breast milk, and not a large enough amount of buprenorphine transmitted via breast milk to produce acute adverse effects; and

Whereas, The benefits of breastfeeding with physician supervision has been found to supersede the risk of opioid exposure since it decreases the rate and severity of NAS in infants born to mothers undergoing opioid maintenance therapy, and is advised by The American Society of Addiction Medicine; and

Whereas, Seeking treatment for opioid addiction with the guidance of a physician is beneficial to newborn outcomes at any point during pregnancy and the AMA recognizes that breastfeeding is the optimal form of nutrition for breastfeeding infants (AMA Policy H-245.982); and

Whereas, Inadequate access to treatment for opioid addiction, limited options for medication-assisted programs during pregnancy and breastfeeding, lack of expertise among providers caring for opioid dependent pregnant and breastfeeding women and their opioid-exposed neonates, and insufficient resources to care for opioid-exposed neonates in low volume obstetric hospitals are challenges facing breastfeeding opioid dependent mothers, especially in rural and underserved communities; therefore be it

RESOLVED, That our American Medical Association’s Task Force to Reduce Opioid Abuse promote educational resources for opioid dependent mothers on the benefits and risks of breastfeeding while using opioid drugs or during maintenance therapy based on the most recent guidelines (New HOD Policy); and be it further

RESOLVED, That our AMA amend by addition existing AMA Policy H-420.962, “Perinatal Addiction - Issues in Care and Prevention,” to read as follows:

Perinatal Addiction - Issues in Care and Prevention H-420.962

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant and breastfeeding women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant and breastfeeding women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. (Modify Current HOD Policy)

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

Received: 09/12/17

RELEVANT AMA POLICY

Perinatal Addiction- Issues in Care and Prevention H-420.962

Our AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant and breastfeeding patients with substance use disorders should be provided with physician-led, team-based care that is evidence-based and offers the ancillary and supportive services that are necessary to support rehabilitation; and (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol use during pregnancy and breastfeeding and to routinely inquire about alcohol and drug use in the course of providing prenatal care. Citation: CSA Rep. G, A-92 Reaffirmation A-99 Reaffirmation A-09 Modified and Reaffirmed: CSAPH Rep. 1, A-09 Modified: Alt. Res. 507, A-16

See also: Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone D-120.985; Medical Direction of Methadone Treatment H-95.977; AMA Support for Breastfeeding H-245.982
Whereas, Over 420,000 children are within the foster care system according to the most recent data from the U.S. Department of Health & Human Services;¹ and

Whereas, A 2014 study indicates 48.3% of children within the foster care system experience four or more adverse family experiences, and these traumatic experiences lead to and include being removed from one’s home;² and

Whereas, Adults who had a history of being in the foster care system had significantly higher rates than the general population of post-traumatic stress disorder and toxic stress-related symptoms, such as attachment disorders, affect dysregulation, and behavior control issues;³,⁴ and

Whereas, Toxic stress and childhood trauma can impact a child’s immune system, neurodevelopment, and genome resulting in delays in cognitive, behavioral, and physical development, in addition to leading to poor health outcomes into adulthood, such as alcoholism, chronic obstructive pulmonary disease, depression, cancer, obesity, increase in suicide attempts, and ischemic heart disease;³,⁵,⁶,⁷,⁸ and

Whereas, Children within the foster system face unique legal and social barriers including limited healthcare records, difficulty in identifying who can consent to care for the child, court mandated treatments, and limited resources;⁹,¹⁰,¹¹,¹² and

Whereas, Screenings, such as the Ages and Stages Questionnaire, can double the detection rate of developmental delay and lead to earlier intervention among children in foster care;¹³ and

Whereas, The American Academy of Pediatrics identifies fifteen Models of Care which can be used for further creation of foster care clinics;¹⁴ and

Whereas, Existing foster care clinics, while limited in number, provide coordination of care, screenings regarding normal development, and transition support for the child and foster families;¹⁴,¹⁵ therefore be it

RESOLVED, That our American Medical Association advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children. (New HOD Policy)

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

Received: 09/20/17

RELEVANT AMA POLICY

Child Protection Legislation H-60.948
Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse D-515.982


Whereas, Studies have demonstrated that conventional and unconventional methods of oil extraction, including acidization, vertical and horizontal drilling, and drilling in urban areas releases volatile organic compounds and heavy metals into local communities, including but not limited to methanol, ozone, crystalline silica, methanol, hydrochloric acid, formaldehyde, hydrofluoric acid, naphthalene, xylene, and ethylbenzene;¹ ² and

Whereas, Naphthalene, methanol, formaldehyde, hydrochloric acid and hydrofluoric acid are associated with damage to multiple organ systems, including but not limited to the skin, eyes, and lungs, ozone increases smog production and the incidence of asthma, and chronic exposure to crystalline silica causes lung and autoimmune diseases;³ ⁴ ⁵ ⁶ and

Whereas, Urban oil wells, drilling and refining facilities are often located close to residences, schools, hospitals, and religious institutions, especially in low income communities and communities of color;⁷ ⁸ ⁹ and

Whereas, Proximity to oil and gas development activities has been associated with reproductive abnormalities including congenital heart abnormalities, premature birth, high risk pregnancies, and low birth weight;¹⁰ ¹¹ ¹² and

Whereas, Individuals within one kilometer (3,280 feet) of well stimulation or other urban oil and gas development activities demonstrate higher rates of self-reported skin and respiratory symptoms including asthma, headache, nausea, epistaxis, experience greater ambient noise levels, and have a higher incidence of leukemia and a higher hazard index for chronic disease;¹³ ¹⁴ ¹⁵ ¹⁶ and

⁵ McConnell, R. et al. Childhood Incident Asthma and Traffic-Related Air Pollution at Home and School. Environmental Health Perspectives; 2014, 118 (7): 1021–26
⁶ Bang, KM. et al. Silicosis mortality trends and new exposures to respirable crystalline silica—United States 2001-2010. CDC M&M Weekly Report; 2015, 64:5. Available at:
Whereas, Numerous states, cities, and towns have enacted buffer zones or setbacks ranging from 150 to 1,500 feet (45 to 407 meters) between well stimulation and sensitive public land uses, commissioned research into buffer zone distances, or banned drilling activities completely; therefore be it RESOLVED, That our American Medical Association amend Policy H-135.949 by addition and deletion to read as follows:

**Support of Clean Air and Reduction in Power Plant Emissions H-135.949**

Our AMA supports (1) federal legislation and regulations that meaningfully reduce the following four major power plant emissions: mercury, carbon dioxide, sulfur dioxide and nitrogen oxide; and (2) efforts to limit carbon dioxide emissions through the reduction of the burning of coal in the nation’s power generating plants, efforts to improve the efficiency of power plants, substitution of natural gas in lieu of other carbon-based fossil fuels, and continued development, promotion, and widespread implementation of alternative renewable energy sources in lieu of carbon-based fossil fuels. (Modify Current HOD Policy); and be it further RESOLVED, That our AMA support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions. (New HOD Policy)

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

Received: 09/20/17

**RELEVANT AMA POLICY**

**Green Initiatives and the Health Care Community H-135.939**

Our AMA supports: (1) responsible waste management policies, including the promotion of appropriate recycling and waste reduction; (2) the use of ecologically sustainable products, foods, and materials when possible; (3) the development of products that are non-toxic, sustainable, and ecologically sound; (4) building practices that help reduce resource utilization and contribute to a healthy environment; and (5) community-wide adoption of 'green' initiatives and activities by organizations, businesses, homes, schools, and government and health care entities. CSAPH Rep. 1, I-08 Reaffirmation A-09 Reaffirmed in lieu of Res. 402, A-10 Reaffirmed in lieu of: Res. 504, A-16

See also: Global Climate Change: The “Greenhouse Effect” (H-135.977); AMA Advocacy for Environmental Sustainability and Climate (H-135.923); Green Initiatives and the Health Care Community (H-135.939); The Health Risks of Hydraulic Fracturing (H-135.931); Environmental Health Programs (H-135.969); Stewardship of the Environment (H-135.973); Modern Chemicals Policies (H-135.942); Clean Air (H-135.991); Reducing Sources of Diesel Exhaust (D-135.996); The Need for Increased Research and Development in Nuclear Fusion to Reduce Environmental Pollution (H-460.956); Air Pollution and Public Health (H-135.941); Air Pollution and Public Health (D-135.985); Expense of Biohazardous Waste Removal (H-135.953); Pollution Control and Environmental Health (H-135.996); AMA Position on Air Pollution (H-135.998); Clean Air (H-135.979); Risks of Nuclear Energy and Low-Level Ionizing Radiation (H-455.994); Childhood Anaphylactic Reactions (D-60.976); Asthma Control (H-160.932); Protective NAAQS Standard for Fine Particulate Matter ((PM-2.5) (H-135.946)); Support the Health-Based Provisions of the Clean Air Act (H-135.950); Protective NAAQS Standard for Fine Particulate Matter ((PM-2.5) (D-135.983)); Protective NAAQS Standard for Particulate Matter ((PM 2.5 and PM 10) (D-135.978)); Support of Clean Air and Reduction in Power Plant Emissions (H-135.949); Federal Clean Air Legislation (H-135.984)

17 McKenzie, LM. et al. Human health risk assessment of air emissions from development of unconventional natural gas
Whereas, The opioid epidemic continues to ravage most of the nation; and
Whereas, Deaths from opioid overdose are rising; and
Whereas, Fentanyl and carfentany are increasingly mixed with the heroin being sold by drug dealers, with an associated increased risk of fatal overdose; and
Whereas, The use of fentanyl and carfentany increases the likelihood that the overdose state will return after successful revival with the first dose of naloxone; and
Whereas, The average opioid-addicted individual relapses multiple times and often overdoses multiple times before successful sobriety; and
Whereas, Individuals who have undergone the training program as laypersons typically receive only one dose of intranasal naloxone; and
Whereas, As opioid use grows, there is an increasing risk of overdoses occurring in crowded public areas and events; therefore be it

RESOLVED, That our American Medical Association study the practicality and utility of Naloxone rescue stations (public availability of Naloxone through wall-mounted display/storage units that also include instructions). (Directive to Take Action)

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

Received: 09/26/17
Whereas, At least one in seven women experience anxiety or depression during pregnancy or in the first year after birth, making mental health disorders the most common complication of pregnancy;¹ and

Whereas, Despite the prevalence of anxiety and depression during pregnancy, maternal depression remains highly underdiagnosed and undertreated, with only 15 percent of women seeking professional evaluation for depressive symptoms (compared with 26% in the general population);¹ and

Whereas, Growing evidence has demonstrated that maternal depression during the antenatal and postpartum periods increases the risk for many adverse outcomes among women and their children (including, poor cognitive outcomes in offspring and increased suicide rates among postpartum women);² ³ and

Whereas, There may be missed opportunities for screening women in an outpatient setting;⁴ ⁵ and

Whereas, The American Congress of Obstetricians and Gynecologists recommends women be screened at least once for depression during pregnancy and once during the postnatal period;⁴ ⁵ and

Whereas, The American Academy of Pediatrics (AAP) recommends pediatricians screen mothers for depression at well-baby visits during the first six months;⁴ ⁵ and

Whereas, The AAP also recommends postpartum depression screening of mothers with low acuity complaints presenting to a pediatric emergency department with their child;⁴ ⁵ and

Whereas, Many obstetricians or pediatricians, who are often at the frontline of diagnosis, lack training in responding to maternal mental-health concerns;⁴ ⁵ and

Whereas, A statewide program called Massachusetts Child Psychiatry Access Program (MCPAP) for Moms provides a full-time consulting care coordinator available for pediatricians or other providers seeking advice on the appropriate treatment of a depressed pregnant or breastfeeding woman; and

Whereas, Treatments through MCPAP can include consultation with a perinatal psychiatrist, individual or group therapy geographically convenient for patients, medications, home visits by a nurse or social worker, or simply a follow-up phone call; therefore be it

RESOLVED, That our American Medical Association work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care. (Directive to Take Action)

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

Received: 09/28/17

RELEVANT AMA POLICY

Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

Our AMA: (1) supports improvements in current mental health services for women during pregnancy and postpartum; (2) supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; (3) supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and (4) will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis, and substance use disorder through research, public awareness, and support programs.

Citation: Res. 102, A-12; Modified: Res. 503, A-17

Access to Mental Health Services D-345.997

Our AMA will: (1) continue to work with relevant national medical specialty societies and other professional and patient advocacy groups to identify and eliminate barriers to access to treatment for mental illness, including barriers that disproportionately affect women and at-risk populations; (2) advocate that psychiatrists and other physicians who provide treatment for mental illness be paid by both private and public payers for the provision of evaluation and management services, for case management and coordination efforts, and for interpretive and indirect services; and (3) advocate that all insurance entities facilitate direct access to a psychiatrist in the referral process.

Citation: CMS Rep. 9, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 804, I-13; Reaffirmed in lieu of Res. 808, I-14; Modified: Res. 503, A-17

See also: Access to Mental Health Services H-345.981

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WHEREAS, Inequalities in determinants of health and health outcomes continue to exist, with the
color of a patient’s skin determining, at least in part, the quality of their health care\(^1\); and

WHEREAS, Some of these disparities are due to differential treatment and care by physicians\(^8\); and

WHEREAS, An ever-increasing number of patients in the United States identify as a member of a
minority group, including approximately 38% of the current population\(^13\); and

WHEREAS, Recognition of implicit bias and training in diversity and inclusion may mitigate both
intentional and unintentional disparities in the provision of care to minority patients\(^14\); and

WHEREAS, Reducing disparities requires national leadership to coordinate thoughtful, intentional
action by leaders at each medical school and residency training program; therefore be it

RESOLVED, That our American Medical Association: (1) actively support the development and
implementation of training implicit bias, diversity and inclusion as a component of medical
education in all medical schools and residency programs; (2) identify and publicize effective
strategies for educating residents in all specialties about disparities in their fields according to
race and ethnicity, with particular regard to access to care and health outcomes; and (3) support
research to identify the most effective strategies for educating physicians on how to eliminate
disparities in health outcomes according to race and ethnicity. (Directive to Take Action)

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

Received: 09/06/17

\(^1\) Institute of Medicine. Unequal treatment: confronting racial and ethnic disparities in health care. National Academies Press,
\(^2\) U.S. Department of Health and Human Services. HHS Action plan to reduce Racial and ethnic health disparities: a nation free of
\(^3\) VS Tammana, AO Laiyemo. Colorectal cancer disparities: issues, controversies and solutions. World J Gastroenterol,
\(^5\) M Sun, PI Karakiewicz, JD Sammon, et al. Disparities in selective referral for cancer surgeries: implications for the current
\(^6\) ER Pouget, BS West, B Tempalski, et al. Persistent racial/ethnic disparities in AIDS diagnosis rates among people who inject
\(^7\) Riley WJ. Health Disparities: Gaps in Access, Quality and Affordability of Medical Care. Transactions of the American Clinical and
Strategies for Enhancing Diversity in the Physician Workforce D-200.985

1. Our AMA, independently and in collaboration with other groups such as the Association of American Medical Colleges (AAMC), will actively work and advocate for funding at the federal and state levels and in the private sector to support the following: a. Pipeline programs to prepare and motivate members of underrepresented groups to enter medical school; b. Diversity or minority affairs offices at medical schools; c. Financial aid programs for students from groups that are underrepresented in medicine; and d. Financial support programs to recruit and develop faculty members from underrepresented groups.

2. Our AMA will work to obtain full restoration and protection of federal Title VII funding, and similar state funding programs, for the Centers of Excellence Program, Health Careers Opportunity Program, Area Health Education Centers, and other programs that support physician training, recruitment, and retention in geographically-underserved areas.

3. Our AMA will take a leadership role in efforts to enhance diversity in the physician workforce, including engaging in broad-based efforts that involve partners within and beyond the medical profession and medical education community.

4. Our AMA will encourage the Liaison Committee on Medical Education to assure that medical schools demonstrate compliance with its requirements for a diverse student body and faculty.

5. Our AMA will partner with key stakeholders (including but not limited to the Association of American Medical Colleges, Association of American Indian Physicians, Association of Native American Medical Students, We Are Healers, and the Indian Health Service) to study and report back by July 2018 on why enrollment in medical school for Native Americans is declining in spite of an overall substantial increase in medical school enrollment, and lastly to propose remedies to solve the problems identified in the AMA study.

6. Our AMA will develop an internal education program for its members on the issues and possibilities involved in creating a diverse physician population.

7. Our AMA will provide on-line educational materials for its membership that address diversity issues in patient care including, but not limited to, culture, religion, race and ethnicity.

8. Our AMA will create and support programs that introduce elementary through high school students, especially those from groups that are underrepresented in medicine (URM), to healthcare careers.

9. Our AMA will create and support pipeline programs and encourage support services for URM college students that will support them as they move through college, medical school and residency programs.

10. Our AMA will recommend that medical school admissions committees use holistic assessments of admission applicants that take into account the diversity of preparation and the variety of talents that applicants bring to their education.

11. Our AMA will advocate for the tracking and reporting to interested stakeholders of demographic information pertaining to URM status collected from Electronic Residency Application Service (ERAS) applications through the National Resident Matching Program (NRMP).

12. Our AMA will continue the research, advocacy, collaborative partnerships and other work that was initiated by the Commission to End Health Care Disparities.

See also: Reducing Racial and Ethnic Disparities in Health Care D-350.995, Diversity in the Physician Workforce and Access to Care D-200.982
Whereas, The process of board certification has a central role in self-regulation of physician
quality standards; and

Whereas, Each specialty has established non-profit organizations to administer this required
evaluation to obtain and maintain board certification; and

Whereas, These organizations charge fees for the examination process that averages
$110.00/year for family medicine to $610.00 per year for colon-rectal surgery; and

Whereas, The physicians taking the examination incur other costs such as review courses,
travel expenses, and lost wages from their current practice; and

Whereas, Physician reimbursement has declined for many and further complicates the process
involved in the cost of taking the exam; and

Whereas, The cumulative net assets of the various certifying organizations as stated in the
reference below, is excessive and totals more than 584 million dollars (JAMA, August 1, 2017,
Volume 318, #5: pages 477-479); therefore be it

RESOLVED, That our American Medical Association request reductions in Maintenance of
Certification examination fees so as to work towards a balanced/neutral budget of ABMS
medical boards given their status as non-profit organizations. (Directive to Take Action)

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

Received: 09/18/17

The topic of this resolution is currently under study by the Council on Medical Education
Whereas, Approximately 70% of the determinants of health status can be traced to environmental, preventive and life-style factors that are influenced by both primary care - patient and public health - community interventions of physicians; and

Whereas, There is a shortage of expertise in both such specialties, especially in rural communities; and

Whereas, Although many primary care physicians serve as “health officers”, other non-physician (even non-health professional) individuals with limited public health knowledge and skills lead the public health community effort in most rural communities; and

Whereas, Many primary care physicians have expressed a desire to greatly expand their public health/population health capacities, competencies and community leadership involvement but are not in a position to leave their practices for long periods to obtain board eligibility in preventive medicine and public health; and

Whereas, Many of these physicians have expressed a willingness to obtain the requisite public health board competencies through alternate “experiential” preceptorships, short didactic courses and other arrangements, while still maintaining the integrity of their practice; and

Whereas, The development of such expertise would greatly improve public health leadership, competencies and performance in such communities while, also, increasing physician presence and influence in overall community health policy and activities; therefore be it

RESOLVED, That our American Medical Association study, with the participation of the appropriate educational and certifying entities, innovative approaches that could be developed and/or implemented to promote interested physicians to obtain board eligibility in preventive medicine/public health to strengthen public health leadership, especially in rural communities. (Directive to Take Action)

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

Received: 09/01/17
Introduced by: International Medical Graduates Section

Subject: Minimization of Bias in the Electronic Residency Application Service

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

Whereas, The current Electronic Residency Application Service (ERAS) Residency Application should conform to the requirements of the U.S. Equal Employment Opportunity Commission (EEOC) by blinding the ERAS Residency Application to the “applicant’s age, race, religion, national origin”;¹ and

Whereas, The ERAS Residency Application has non-academic identifiers (including a picture) that may identify or suggest age, race, religion, and/or national origin, placed at the beginning of the application which may contribute to bias including, but not limited to, the priming effect;²⁻⁶ and

Whereas, Conscious and unconscious bias, that may influence the selection of a resident, may be associated with many identifiers revealed at the beginning of the ERAS Residency Application including, but not limited to, age, race, religion, national origin, weight, gender, sexual orientation, transgender status, and attractiveness;⁷⁻¹⁰ and

Whereas, Bias has been associated with school admissions and hiring;⁶,¹⁰ and

Whereas, This bias should be minimized to ensure fairness in residency trainee selection; therefore be it

RESOLVED, That our American Medical Association advocate for the formation of an Electronic Residency Application Service (ERAS) Residency Application Bias Minimization Committee to examine the role of bias in the residency training selection process¹¹ (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for the modification of the ERAS Residency Application to minimize its bias in accordance with the suggestions of the ERAS Residency Application Bias Minimization Committee. (Directive to Take Action)

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

Received: 09/22/17
References:

RELEVANT AMA POLICY

Gender-Based Questioning in Residency Interviews H-310.976
The AMA (1) opposes gender-based questioning during residency interviews in both public and private institutions for the purpose of sexual discrimination; (2) supports inclusion in the AMA Fellowship and Residency Interactive Database Access (FREIDA) system information on residency Family and Medical Leave policies; and (3) supports monitoring the Accreditation Council for Graduate Medical Education as it proposes changes to the "Common Requirements" and the "Institutional Requirements" of the "Essentials of Accredited Residencies," to ensure that there is no gender-based bias.

Eliminating Questions Regarding Marital Status, Dependents, Plans for Marriage or Children, Sexual Orientation, Gender Identity, Age, Race, National Origin and Religion During the Residency and Fellowship Application Process H-310.919
Our AMA:
1. opposes questioning residency or fellowship applicants regarding marital status, dependents, plans for marriage or children, sexual orientation, gender identity, age, race, national origin, and religion.
2. will work with the Accreditation Council for Graduate Medical Education, the National Residency Matching Program, and other interested parties to eliminate questioning about or discrimination based on marital and dependent status, future plans for marriage or children, sexual orientation, age, race, national origin, and religion during the residency and fellowship application process.
3. will continue to support efforts to enhance racial and ethnic diversity in medicine. Information regarding race and ethnicity may be voluntarily provided by residency and fellowship applicants.
Res. 307, A-09

Oppose Discrimination in Residency Selection Based on International Medical Graduate Status D-255.982
Our AMA:
1. Will request that the Accreditation Council for Graduate Medical Education include in the Institutional Requirements a requirement that will prohibit a program or an institution from having a blanket policy to not interview, rank or accept international medical graduate applicants.
2. Recognizes that the assessment of the individual international medical graduate residency and fellowship applicant should be based on his/her education and experience.
3. Will disseminate this new policy on opposition to discrimination in residency selection based on international medical graduate status to the graduate medical education community through AMA mechanisms.
Sub. Res. 305, A-08 Reaffirmation I-11

See also: Eliminating Religious Discrimination from Residency Programs H-310.923
Whereas, In order to practice clinical medicine in an unsupervised setting, all physicians (international medical graduates and domestic graduates) must be licensed by the medical licensing board of the state where they plan to practice; and

Whereas, International medical graduates (IMGs) must be certified by the Educational Commission for Foreign Medical Graduates (ECFMG) and must pass USMLE Steps 1, Step 2 CK and Step 2 CS; and

Whereas, When a physician receives ECFMG certification, he/she may apply for an ACGME accredited residency; and

Whereas, Many ECFMG-certified IMGs are waiting to get into a residency program, but are unable to obtain a residency due to the limited number of residency slots available; and

Whereas, A significant shortage of primary care physicians is predicted ranging between 8,700 and 43,100 physicians by 2030;¹ which will further impact the availability of physicians and health care providers to care for patients in underserved areas of the United States;² and

Whereas, The Florida State Medical Board has implemented policies and laws to allow hospitals to employ physicians who have limited medical licenses as “house physicians” to work under the direct supervision of a physician who has an active Florida medical license and provide care to patients³; therefore be it

RESOLVED, That our American Medical Association work with state legislators and other regulatory organizations to develop the category of “House Physicians” to help address the anticipated physician need and shortfall of available practitioners in underserved areas of the United States. (Directive to Take Action)

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

Received: 09/22/17

References:
Whereas, Current Accreditation Council for Graduate Medical Education (ACGME) guidelines state that accredited obstetrics and gynecology (OB-GYN) residencies are required to provide access to abortion training in their curriculum, which the American Congress of Obstetricians and Gynecologists (ACOG) recognizes is a necessary component of women’s health care; and

Whereas, ACGME requires that all programs be held to the same high standards; however, ACOG reports that programs differ widely in scope and types of training offered; and

Whereas, There are many institutional barriers to medical education surrounding abortion, including legislative, societal, and monetary, all of which contribute to the limited access to family planning training opportunities; and

Whereas, Many institutions do not provide equal access to abortion training during OB-GYN residency training, only 54 percent of OB-GYN residents from 161 programs noted routine integrated abortion training, and 16 percent reported that elective training was not available; and

Whereas, In a 10-year study of Ryan Residency programs—which offer enhanced, integrated family planning education in OB-GYN residencies—there was a demonstrated 97 percent improved competency in abortion and contraceptive care, but they only make up 32 percent of all US OB-GYN residency programs; and

Whereas, Offering comprehensive, integrated training in abortion and family planning has shown to improve residents’ competency and proficiency in abortion, counseling, miscarriage management, and other reproductive care; and

Whereas, ACOG supports expansion of abortion training, and the improvement and integration of abortion education throughout all levels of medical education; and

Whereas, AMA policy supports the opportunity for residents to learn or opt-out of pregnancy termination procedures and opposes program measures aimed to interfere with or restrict the availability of this training; and

Whereas, AMA policy maintains that basic skills and competencies be determined solely by the medical profession; therefore be it
RESOLVED, That our American Medical Association encourage the Accreditation Council for Graduate Medical Education to better enforce compliance with the standardization of abortion training opportunities as per the American Congress of Obstetricians and Gynecologists’ recommendations. (Directive to Take Action)

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

Received: 09/29/17

RELEVANT AMA POLICY

Medical Training and Termination of Pregnancy H-295.923
The AMA supports the education of medical students, residents and young physicians about the need for physicians who provide termination of pregnancy services, the medical and public health importance of access to safe termination of pregnancy, and the medical, ethical, legal and psychological principles associated with termination of pregnancy, although observation of, attendance at, or any direct or indirect participation in an abortion should not be required. Further, the AMA supports the opportunity for residents to learn procedures for termination of pregnancy and opposes efforts to interfere with or restrict the availability of this training.

Residency Program Responsibility for Resident Education H-295.915
The AMA affirms that the basic skills and competencies for the practice of medicine and its specialties must be determined solely by the medical profession.
Citation: Res. 313, A-96; Reaffirmed: CME Rep. 2, A-06; Reaffirmed: CME Rep. 01, A-16;

1 Accreditation Council for Graduate Medical Education. “ACGME program requirements for graduate medical education in obstetrics and gynecology.” (2013).
Whereas, The cellular biology, gene expression, and hormonal profile differs between sexes and genders, and influence the clinical presentation, progression, and outcome for a variety of diseases; and

Whereas, The Institute of Medicine supports the advent and implementation of sex and gender based medicine in daily practice of patient care due to its multifactorial impact on overall patient health and disease prognosis; and

Whereas, Sex and gender based medical education is a critical component in the pursuit of more personalized medicine; and

Whereas, The majority of current educational materials used in medical education have a gender-bias toward male patients, and educators must make the conscious decision to offer learning materials and teaching that is sex and gender based; and

Whereas, There are demonstrated sex and gender differences in drug responses to therapeutic doses due to variations in gene expression leading to increases in adverse effects disproportionately in the female sex; and

Whereas, Sex and gender-based medicine (SGBM) may not currently be addressed in undergraduate or graduate medical education, and medical students and residents may not fully understand the impact of these differences on patient care; and

Whereas, A recent study shows 96 percent of medical students are aware of differences in SGBM, and 94.2 percent believe including it in the curriculum improves their ability to care for future patients; and

Whereas, Some schools have already adapted their curriculum to include SGBM through integration into existing educational resources, including clinical cases and learning modules; and

Whereas, Over twenty national and international organizations and schools are already addressing sex and gender implications in medical education and continuing medical education curricula; and

Whereas, The AMA has recently expanded the definition of women’s health to be inclusive of all health conditions for which there is evidence that women’s risks, presentations, and/or responses to treatment are different from those of men, and encouraged physicians to use this in their training; and
Whereas, The AMA has previously resolved to encourage the research of sex and gender differences in medicine, and recommends that medical/scientific journals require sex based analysis of data when appropriate; therefore be it

RESOLVED, That our American Medical Association ask the AMA Council on Medical Education and Academic Physician Section to encourage the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to assure the inclusion of sex and gender based medicine in medical education programs across the spectrum of learners nationwide. (Directive to Take Action)

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

Received: 09/29/17

RELEVANT AMA POLICY

An Expanded Definition of Women's Health H-525.976,
Our AMA recognizes the term "women's health" as inclusive of all health conditions for which there is evidence that women's risks, presentations, and/or responses to treatments are different from those of men, and encourages that evidence-based information regarding the impact of sex and gender be incorporated into medical practice, research, and training.
Citation: CSAPH Rep. 05, A-16;

See also: Medical Education and Training in Women's Health H-295.890, Sex and Gender Differences in Medical Research H-525.988
Informational Reports

BOT Report(s)
01 Redefining AMA's Position on ACA and Healthcare Reform
02 2017 AMA Advocacy Efforts
03 Removing Restrictions on Federal Funding for Firearms Violence Research
04 Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care
08 2018 Strategic Plan
09 Parental Leave

CEJA Opinion(s)
01 Amendment to E-2.3.2, "Professionalism in Social Media"

CME Report(s)
02 A National Continuing Medical Education Repository

Report of the Speakers
01 Recommendations for Policy Reconciliation
Subject: Redefining AMA’s Position on ACA and Healthcare Reform

Presented by: Gerald E. Harmon, MD, Chair

At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which called on our American Medical Association (AMA) to “develop a policy statement clearly outlining this organization’s policies” on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, “Redefining AMA’s Position on ACA and Healthcare Reform,” accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

EFFORTS TO REPEAL THE ACA

Efforts to repeal and replace the ACA have consumed the vast majority of health system reform efforts of the 115th Congress and, to date, have been largely unsuccessful. The AMA engaged directly with members of Congress in an effort to shape the outcome of the discussion along the lines of specified principles set forth in AMA policy and approved by the HOD. These were that any legislation should:

- Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
- Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
- Stabilize and strengthen the individual insurance market;
- Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
- Ensure that Medicaid, CHIP and other safety net programs are adequately funded;
- Reduce regulatory burdens that detract from patient care and increase costs;
- Provide greater cost transparency throughout the health care system;
- Incorporate common sense medical liability reforms; and
- Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

A number of factors played into the inability of Congress to advance repeal of the ACA, including the decision to act under the limitations imposed by the budget reconciliation process and efforts to go beyond ACA reform to include significantly restructuring the financing of the Medicaid program without hearings or stakeholder input. Ideological differences among Republican members of Congress and discomfort with projections of significant increases in the number of Americans without health insurance as a result of Congressional action further compromised any pathway to repeal.

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The “American Health Care Act” (AHCA) was reported by the House Budget committee on March 20, 2017 and considered by the House of Representatives on March 24. As considered by the House, the bill made numerous changes to the Medicaid program, most significantly eliminating federal funding for ACA Medicaid expansion populations and converting Medicaid financing into a per-capita allotment. The AHCA effectively eliminated the individual and employer mandates established by the ACA and replaced the current premium assistance tax credit for purchasing health coverage which was based on age, income and the affordability of coverage with an advanceable, refundable credit based primarily on age and phasing out for individuals with higher incomes. Actuarial requirements for plans were eliminated and the permissible variation of premiums by age was increased from 3:1 to 5:1. To compensate for the greater instability in the individual market caused by the elimination of penalties for failure to maintain coverage and other changes, the bill established a Patient and State Stability Fund and required insurers to charge a 30 percent premium surcharge to individuals who failed to maintain coverage for more than 62 days during the previous year. The Congressional Budget Office (CBO) estimated that the bill would result in 14 million fewer Americans with health insurance coverage in 2018, increasing to 26 million by 2026. It would also reduce federal Medicaid expenditures by more than $800 billion over the next decade. Lacking the necessary support, House leadership pulled the bill from consideration prior to a vote.

On May 4, 2017, the House considered a revised version of the AHCA, incorporating amendments by both conservative and moderate members of the House Republican Conference, including: allowing the establishment of Medicaid work requirements; allowing a state to receive Medicaid funding as a block grant; increased funding for maternity coverage, newborn care, and services for those with mental health or substance use disorders; establishment of a risk sharing program for insurers; increased stability funding; state waiver of essential health benefits; and allowing insurers to vary premiums by health status for individuals who had a break in coverage. The modified legislation, considered prior to the availability of a CBO score, was passed by a vote of 217-213. On May 24, the CBO estimated that the House-passed bill would result in 14 million fewer Americans with health insurance coverage in 2018 and 23 million fewer in 2026 while reducing federal Medicaid expenditures by more than $800 billion.

Lacking Senate support for the House-passed AHCA, Senate Republican leadership undertook the drafting of revised legislation. A discussion draft, the “Better Care Reconciliation Act” (BCRA) was released on June 26, 2017. The Medicaid per-capita cap was maintained, though with a more generous growth rate in the short term and a lower allowed growth rate in later years. Funding for Medicaid expansion was also eliminated, though over a longer period of time. Premium tax credits in the Senate bill more closely reflected those in the ACA and a single actuarial benchmark of 58 percent was established for plans. As opposed the AHCA’s 30 percent premium surcharge for those with a gap in coverage, the Senate bill established a six month waiting period before coverage could begin. CBO estimated that the proposal would result in 15 million fewer Americans with health coverage in 2018 and 22 million fewer by 2026. Federal Medicaid expenditures would be reduced by more than $770 billion over the decade.

Despite these efforts, Senate leadership was unable to attract the necessary 50 votes for the proposal from the 52 Republican Senators. While moderate members, especially those from states that had successfully expanded Medicaid, remained concerned with the impact on coverage, a modified draft released on July 13 moved the Senate product decidedly to the right. The proposed amendment would allow insurers to offer plans outside of the exchanges that were exempt from ACA requirements including essential health benefits and pre-existing condition protections, as long as they also offered other compliant plans on the exchanges. To compensate for the impact on the risk pool within the exchange, additional stability funding was included. The measure also
increased funding for opioid abuse treatment and allowed Health Savings Account funds to be used for premiums. Some conservative members continued to argue that the Senate proposal largely kept the structure of the ACA intact – contrary to campaign promises to completely repeal the law. On July 19, another proposal was released called the “Obamacare Repeal Reconciliation Act” (ORRA). The ORRA largely reflected the reconciliation bill passed by the previous Congress but vetoed by President Obama. ORRA would repeal all elements of the ACA allowed under reconciliation, essentially wrecking the individual markets by repealing penalties for failure to maintain coverage while maintaining requirements that insurers offer coverage to all individuals at community rated premiums with no preexisting condition exclusions. CBO estimate that 17 million fewer Americans would have coverage under the ORRA in 2018, increasing to 32 million by 2026. Furthermore, for those purchasing coverage on the exchange, premiums would be double those projected under current law by 2026 and three-quarters of all Americans would live in areas with no plans offered in the non-group market. Federal Medicaid expenditures would be reduced by more than $840 billion over the decade.

On July 25, 2017, the Senate voted 51-50 to proceed to consideration of H.R. 1628, the American Health Care Act. Republican Senators Susan Collins of Maine and Lisa Murkowski of Alaska voted no. Vice President Mike Pence cast the tie-breaking vote. Over the next two days the Senate considered a number of secondary amendments from both sides of the aisle. On July 25, the Senate considered and rejected the “Better Care Reconciliation Act” by a vote of 43-57, with 9 Republicans joining all Democrats in opposition. The following day, the Senate also rejected the “Obamacare Repeal Reconciliation Act” by a vote of 45-55.

Still lacking the necessary 50 votes to advance ACA repeal and facing a growing backlog in the Senate agenda, Senate Majority Leader McConnell offered one last alternative, the “Health Care Freedom Act” (HCFA) or so-called skinny repeal. The HCFA reflected common provisions of previous versions – elimination of individual and employer mandate penalties, eliminate funding for the Prevention and Public Health Fund, extension of the moratorium on the device tax through 2020, a temporary increase in HSA contribution limits, increased section 1332 state waivers, increased Community Health Center Funding, and prohibition of Medicaid payments to Planned Parenthood clinics. While most of these provisions enjoyed unanimous support among Republican senators (the Planned Parenthood provision being the exception), no Senator supported the HCFA as the final Senate position on ACA repeal. Rather, leadership promoted the idea that passage of the amendment would allow the Senate to advance ACA repeal to a conference with the House where yet another new version of the bill could be written. Several Republican senators expressed the concern that the House would instead take up the Senate-passed bill and send it directly to the President. While the House leadership tried to assure the Senate that they would go to conference, messaging from different quarters on the ultimate pathway was decidedly mixed. In the end, in the early morning hours of July 28, the Senate rejected the HCFA by a vote of 49-51, with Sen. John McCain (R-AZ) joining Sens. Collins, Murkowski and all Democrats in voting no. With no viable pathway forward, Sen. McConnell pulled the bill from consideration.

Throughout House and Senate consideration of the AHCA and the Senate substitutes, the AMA consistently advocated that Congress reject proposals that would lead to fewer Americans with access to quality, affordable health care coverage and that were inconsistent with the principles and policies adopted by the House of Delegates. The AMA also consistently acknowledged that there are shortcomings in the ACA and expressed our desire to engage with Congress and other stakeholders in efforts to address those issues. In response to a May 12, 2017 request from Senate Finance Committee Chairman Orrin Hatch (R-UT), the AMA offered a number of policy suggestions to enhance plan affordability, stabilize the individual market, and protect the safety net. The partisan nature of the debate and the limitations imposed by the budget reconciliation process,
however, made advancing those proposals highly unlikely as long as repeal of the ACA remained the primary objective.

At this writing, Congress is expected to turn to efforts to stabilize the current system in the short term, likely through continuing Cost Sharing Reduction payments to health plans and reinsurance. Efforts are also likely to incorporate additional flexibilities for states in administering components of the Affordable Care Act. Members on both sides of the aisle have acknowledged that successful legislative efforts will require regular order – committee hearings, consultation with stakeholders, and compromise on all sides. The AMA will remain engaged in these efforts consistent with the principles outlined above.

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-PERFORMANCE

Since the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), much of the policy making activity related to pay-for-performance programs has been subsumed by implementation activities surrounding that statute. Since the enactment of MACRA, the AMA has worked diligently with the Centers for Medicare & Medicaid Services (CMS) to ensure that the law was implemented in manner that encourages and enables successful participation of physician practices of all sizes and structures, including appropriate exemptions. Proposed rulemaking for 2018 offers further evidence of the success achieved by the AMA and organized medicine in this regard.

The 2018 proposed rule calls for important accommodations for small practices, including expanded low volume thresholds, creation of virtual groups, bonus points for small practices and a new hardship exemption from Advancing Care Information (ACI) (formerly meaningful use). New flexibilities have also been proposed for ACI, including the use of 2014 certified electronic health records technology for 2018. Quality performance will remain weighted at 60 percent and the cost category at zero.

The proposed rule also eliminates the cross cutting measure requirement, maintains the current data completeness threshold, and allows the reporting of improvement activities through attestation while maintaining the number of activities physicians must report.

On the legislative front, the AMA is engaged in efforts to ensure that CMS has the necessary flexibility to promote successful physician participation. This includes efforts to make sure measures of resource use are developed and tested prior to their required implementation and that ACI requirements do not become overly burdensome.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The IPAB was created as part of the Affordable Care Act to reduce the per capita rate of growth in Medicare spending. Recommendations from the IPAB to reduce spending in Medicare are required should the Chief Actuary of CMS Services determine that per-capita spending exceeds a specified target. Should that occur, the IPAB would be required to make recommendations to Congress to bring spending back into line with targets. In doing so, the IPAB is generally prohibited from recommending changes to cost sharing or premiums, rationing care, or changing benefits or eligibility. These limits leave few tools for controlling spending outside of changes to provider payments. The statute also prescribes a specific time table for Congressional action on these recommendations which leaves Congress the option of replacing IPAB-recommended policies with
alternative savings, though Congress would still be required to produce total savings necessary to
match the targets.

At this time, no members have been appointed to the IPAB nor are appointments expected. The
statute contemplates this possibility by calling for the Secretary of U.S. Department of Health and
Human Services (HHS) to make the recommendation directly to Congress in lieu of
recommendations made by an appointed IPAB. However, it is not clear at this time what steps
Secretary Price would take in response to the triggering of the IPAB requirement nor is the position
of the Administration on this issue clear.

Six separate pieces of legislation have been introduced in the 115th Congress to repeal or otherwise
discontinue the functions of the IPAB. Three of these bills, by Sen. John Cornyn (R-TX), Sen. Ron
Wyden (D-OR), and Rep. Phil Roe, MD (R-TN) and Rep. Raul Ruiz, MD (D-CA) are consistent
with legislation that has been introduced in each of the previous Congresses since the enactment of
the ACA. In both the 113th and 114th Congress, bipartisan IPAB repeal legislation was considered
and passed in the House of Representatives but not considered in the Senate. In each case, the bill
was paired with provisions offsetting the cost that were not bipartisan in nature, therefore
diminishing the opportunity for successful enactment.

The second set of proposals, introduced by the same sponsors as the IPAB repeal legislation,
fulfills the requirements of an IPAB discontinuation process that was enacted as part of the IPAB
itself. Section 3403 of the ACA establishes fast track procedures for discontinuing the IPAB
process through a joint resolution that meets specific requirements. Unfortunately, the procedural
advantages offered by these resolutions expired on August 15.

On July 13, 2017, the Medicare Trustees released their annual report. Included was the
determination by the Actuary that spending targets have not been exceeded and therefore IPAB
recommendations are not triggered this year, contrary to earlier predictions. While it is certainly
positive that no cuts are currently required, the lack of a direct threat of cuts has tempered the
urgency of repealing IPAB.

The longer Congress waits to repeal the IPAB, the more expensive it will become given the fact
that the Congressional Budget Office predicts accelerating Medicare spending in future years,
increasing the likelihood of required cuts that must then be offset as part of repeal legislation. This
is unfortunate in that the true urgency lies not in the immediate threat of cuts but in the growing
cost of IPAB repeal.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS,
AND THE MEDICARE PATIENT EMPOWERMENT ACT

Our AMA continues to seek opportunities to expand the use of health savings accounts and remove
ACA imposed limitations on the allowed use of Flexible Spending Account funds.

Our AMA continues to work with the Health Choices Coalition in support of the “Restoring Access
to Medications Act” which has been reintroduced by Rep. Lynn Jenkins (R-KS), Rep. Ron Kind
(D-WI), Sen. Pat Roberts (R-KS) and Sen. Heidi Heitkamp (D-ND). This legislation would repeal
ACA-imposed limitations on the use of Flexible Spending Account funds to purchase over-the-
counter medications without a prescription.

Our AMA also continues to pursue opportunities to expand the availability of Health Savings
Accounts (HSA) consistent with AMA objectives for continuing health system reform. In
suggestions provided to Sen. Hatch on improving health care affordability, for example, the AMA suggested allowing individuals who are eligible for cost sharing reductions to forgo those reductions and instead enroll in a bronze plan with a prefunded HSA and allow those funds to roll over from year to year. We also proposed providing individuals not eligible for cost sharing reductions with a moderately funded HSA.

The Medicare Patient Empowerment Act has not been reintroduced in the 115th Congress. AMA will continue to seek opportunities, however, to increase private contracting opportunities under the Medicare program without penalty to the patient or physician.

STEPS TO LOWER HEALTH CARE COSTS

Beyond AMA’s extensive efforts to prevent chronic disease currently underway through the Improving Health Outcomes initiative, there are multiple opportunities in the policy arena to bring down the cost of care, among them are focusing on the rising cost of prescription drugs and the opportunity to lower the cost of providing care through regulatory reforms.

Though Congress’ attention has been focused on the Affordable Care Act, the AMA continues to work to build support for addressing the high costs of prescription drugs. Drawing on policies adopted by the House of Delegates in 2015 and 2016, and the work of an AMA task force consisting of AMA councils, state medical associations and national medical specialty associations, the AMA continues to explore opportunities to increase transparency in the pharmaceutical sector. These efforts include a website, TruthinRx.org where patients can access information and share their stories as well as sign an online petition. We believe that Congress will turn its attention to pharmaceutical pricing in the near future and the AMA is ready to fully engage at that time.

Achieving lower cost care is also dependent on reducing the cost to the physician to provide care by eliminating administrative burdens that do not contribute to better care. Our AMA continues to engage both Congress and the new Administration on a variety of proposals to reduce regulatory burden in the areas of certification and documentation, Medicare Advantage, Part D prior authorization requirements, Appropriate Use Criteria, Meaningful Use and Electronic Health Records, Program Integrity, DEA requirements, and FDA regulation of laboratory developed tests and compounding, to name a few. Some success can already be seen in the MACRA proposals noted above as well as a recent request for information on regulatory reform ideas that was part of the 2018 Medicare Physician Fee Schedule proposed rule released in July. Additionally, the House Committee on Ways and Means has initiated an effort to collect suggestions for both statutory and regulatory changes to “deliver relief from unnecessary and burdensome mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries.” The AMA is participating fully in these and other efforts to reduce regulatory burdens.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE ACA

Guidance released by the Department of Health and Human Services in 2014 included a positive interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying that the section does not require “that a group health plan or health insurance issuer contract with any provider willing to abide by the terms and conditions for participation.” Nevertheless, the AMA will continue to seek legislative opportunities to repeal this provision.
CONCLUSION

To date, much of the effort surrounding health system reform in the 115th Congress has been focused on efforts to repeal the Affordable Care Act. While we are pleased that those proposals have been unsuccessful to date, we will remain engaged in efforts to address the shortcomings of the ACA by vigorously pursuing the adoption of AMA policies on health care coverage and health system reform. Additionally, we will continue to seek opportunities both in the legislative and regulatory arenas to advance policies promoting the successful implementation of MACRA, the reduction of regulatory burdens on physicians, the repeal of IPAB, lowering of health care costs and other policies adopted by the House of Delegates.
EXECUTIVE SUMMARY

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared the following report to provide an update on 2017 American Medical Association (AMA) advocacy activities.

The AMA had another strong year on the advocacy front. We were able to advance patient and physician interests in several areas. We were also able to defend against potential rollbacks of hard-fought gains. Our efforts centered on the following issues.

- The AMA led medicine’s effort to protect coverage and access to quality, affordable health care for patients which were threatened in the 115th Congress.
- The AMA sought and attained numerous improvements to the implementation regulations for the Medicare Access and CHIP Reauthorization Act (MACRA) – or Quality Payment Program (QPP) as it is now known.
- The AMA continued to educate and create tools for physicians to help them with the transition to MACRA/QPP.
- The AMA pursued legislative and regulatory initiatives to reduce administrative burdens on physician practices to improve efficiency and reduce burnout.
- The AMA, in conjunction with our Federation colleagues, played a major role in the defeat of two health insurer mega-mergers – one of which could have led to physician payment cuts of $500 million per year.
- The AMA has successfully called on the Centers for Medicare & Medicaid Services to provide coverage for the Medicare Diabetes Prevention Program which directly addresses one of our nation’s most prevalent diseases.
- The AMA continues to address the opioid epidemic, and our main recommendations on physician use of Prescription Drug Monitoring Programs, continuing medical education, naloxone, and others are having positive results. However, the overdose and death rates remain staggering.
- The AMA is working to limit the inappropriate use of prior authorization which is a major impediment for physicians as they seek to provide optimal care to their patients.
- The AMA has also launched a campaign calling for greater transparency in the pricing process for prescription drugs by pharmaceutical companies, pharmacy benefit managers, and health insurers.

Staff note: This report was prepared in September 2017, and may be updated prior to the Interim Meeting based on more recent advocacy developments.
BACKGROUND

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared the following report to provide an update on 2017 American Medical Association (AMA) advocacy activities.

DISCUSSION OF 2017 ADVOCACY EFFORTS

Health System Reform

When the 115th Congress convened on Jan. 3, 2017, it was clear that health system reform would be a top priority for both chambers. In anticipation of the coming debates, the AMA outlined our key objectives for health system reform which are based on AMA policy and sent them to the Administration and Congress urging them to align any legislative proposals with these objectives.

• Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
• Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
• Stabilize and strengthen the individual insurance market;
• Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
• Ensure that Medicaid, CHIP and other safety net programs are adequately funded;
• Reduce regulatory burdens that detract from patient care and increase costs;
• Provide greater cost transparency throughout the health care system;
• Incorporate common sense medical liability reforms; and
• Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

Subsequently, the House and the Senate both introduced legislation at various points that would repeal key portions of the Affordable Care Act (ACA). The AMA analyzed the House bill, the American Health Care Act (AHCA), and the Senate bill, the Better Care Reconciliation Act (BCRA), in relation to our health reform objectives and determined that both bills fell short when compared to those objectives. According to the Congressional Budget Office (CBO), the AHCA and BCRA would both have led to over 20 million or more Americans losing their health care coverage. The bills included per capita caps on Medicaid funding, which the AMA opposes based on explicit policy adopted at our 2017 Annual Meeting. The bills would have also led to increased costs for patients. Therefore, the AMA opposed the bills as originally introduced and as they were
amended through the process (as did a long list of other health organizations). The AHCA eventually passed the House in May by a vote of 217-213. The Senate efforts, BCRA and other repeal bills, have stalled in the Senate as of this writing.

The AMA launched a vibrant and effective campaign to oppose both of these bills.

- The AMA created a website, PatientsBeforePolitics.org, to serve as our grassroots platform for patient and physician engagement on these issues.
- The AMA also launched an extensive grassroots campaign involving telephone calls, emails, social media contacts and meetings with key Senators. The results were very strong: 6,290,404 digital/social media engagements; 380,264 emails; and 33,618 phone calls as of this writing.
- The AMA commissioned public opinion polls in select states, revealing that registered voters support Medicaid and opposed the proposed repeal/replace bills.
- The AMA joined collaborative efforts with patient groups, hospitals and other providers for media events held in Colorado, Ohio, Nevada, and West Virginia to share personal stories about the impact that access to affordable, meaningful health insurance coverage has had on individuals, families and communities.

The AMA will continue to offer short-term and long-term recommendations and solutions to Congress as it revisits the health reform debate. We are on the record that the status quo is unacceptable and that problems with the ACA must be fixed. The immediate focus is individual insurance market stability to provide affordable coverage and choice. We are working with both parties in Congress to advance these and other interventions.

MACRA/QPP Implementation

Addressing practice sustainability is a major objective for the AMA. The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 (being implemented as the Quality Payment Program [QPP]) repealed the Sustainable Growth Rate and made several improvements over previous law including aligning and reforming a number of existing Medicare programs such as Meaningful Use, Physician Quality Reporting System (PQRS) and the Value-based Modifier (VM). It also created a way for physicians to participate in alternative payment models (APMs) and provided a path to advance them. Since MACRA’s enactment, the AMA has been advocating to the Centers for Medicare & Medicaid Services (CMS) to ensure that the QPP regulations implementing MACRA are workable for physician practices and do not create new hurdles. The AMA has also launched an extensive campaign to educate physicians about MACRA and to help them prepare for the transition.

On the regulatory implementation front, the AMA, working with our Federation partners, attained several major improvements in the QPP for physicians in last year’s QPP rule. For example, CMS instituted the Pick Your Pace program for 2017. Under Pick Your Pace, physicians will not face a potential four percent payment reduction in 2019 if they report on one measure for one patient in 2017. Only physicians who do not report any data to Medicare in 2017 will receive a penalty. To help physicians understand how to report, the AMA created a video that explains in detail how to report and avoid the penalty. While this year’s QPP rule included several positive aspects, we continued to make recommendations to CMS on how to further improve the program.

In the QPP proposed rule for the 2018 performance period, CMS has proposed several more improvements in response to issues raised by the AMA, including several concerns facing small practices.
• Expanding significantly the low-volume threshold to $90,000 or less in Medicare Part B allowed charges OR 200 or fewer Medicare Part B patients (previously the threshold was $30,000 in allowed charges or 100 patients) – CMS estimates that only 37 percent of clinicians who bill Medicare will be subject to the Merit-based Incentive Payment System (MIPS);
• Allowing the establishment of virtual groups to assist small practices;
• Adding five bonus points to the final MIPS scores for practices of 15 or fewer clinicians;
• Adding a hardship exception from the Advancing Care Information (previously Meaningful Use) category for practices of 15 or fewer clinicians; and
• Allowing the use of 2014 edition certified electronic health records technology (CEHRT) past 2017, and CMS will not mandate that physicians update their EHRs in 2018.

The proposed rule also contains a number of other positive provisions, such as:
• Eliminating the cross cutting measure reporting requirement;
• Not increasing the data completeness threshold requirement;
• Proposing a zero weight for costs again in the 2018 performance/2020 payment year;
• Allowing physicians to report on Improvement Activities (IA) through simple attestation;
• Not increasing the number of IAs physicians must report;
• Developing additional IAs; and
• Keeping the revenue standard for Alternative Payment Models for more than nominal financial risk at 8 percent of revenues.

The AMA continues to provide educational resources to physicians and their staff as they prepare for the QPP transition, including webinars, ReachMD podcasts, and the development of resource material. An APM workshop was held in March to convene physicians engaged with their specialties in practice model development to stimulate innovation and share strategies for addressing common problems and concerns. A second workshop is planned for October in Chicago. The Interactive MIPS 2017 Action Plan launched in July and the Payment Model Evaluator will be updated in the fall to reflect changes stemming from the 2018 final rule. For more information, please visit the AMA MACRA/QPP page.

Regulatory Relief

Regulatory relief is a high priority for the AMA. It is also a top initiative for the Trump Administration. To take advantage of this enhanced opportunity to address long-standing concerns with a burgeoning regulatory burden, the AMA established a Federation work group to help pinpoint the key regulatory relief issues the AMA should pursue with the Federal government. Some of the issues include: prior authorization, Medicare beneficiary identification numbers, Medicare documentation and certification requirements, appropriate use criteria (AUC), electronic health records, physician office lab reporting, and program integrity audits. In addition, the AMA, along with members of the Federation, agreed to urge the Administration to modify prior requirements and consequently the 2018 penalties of the PQRS, MU, and VM programs. Such changes would bring these policies more in line with the design of MIPS. Concerns and solutions for these and other administrative burdens have been shared and discussed with various arms of the Administration.

As a result of these efforts, some issues are already being successfully resolved. AMA places streamlining and aligning QPP at the top of our regulatory relief agenda. As outlined above, CMS continues to respond positively to AMA advocacy by modifying QPP. In addition due to direct AMA advocacy, the Administration agreed to create a look up database for new Medicare beneficiary identification numbers that will replace the current Social Security number identifiers.
The Social Security Number Removal Initiative (SSNRI), which will be phased in over a 12-month period starting in April, 2018, will affect all Medicare beneficiaries and their physicians. Consequently, agreement by CMS to establish the database and a communication plan to educate both patients and physicians is an important achievement. The Food and Drug Administration has initiated a process to reduce the administrative barriers that generic drug manufacturers face when entering the market. CMS also decided to delay public reporting of new pain measures until 2020. The AMA and other physician groups convinced the US Pharmacopeia to establish a sub-committee to more thoughtfully consider in-office compounding. Also there were several positive regulatory relief developments in the annual proposed Physician Fee Schedule rule, including reductions in 2018 PQRS, MU and VM penalties, further delays in implementation of AUC, and requests for comments on the burden associated with new physician lab reporting requirements.

In addition to these proposed policy modifications, the 2018 fee schedule proposed rule as well as several other regulations released by the Administration have also launched a broad request for information on regulatory relief. The more concrete and immediate proposals in the proposed rule represent a down payment on these broader initiatives, and while there could be modifications when a final rule is issued in November, the proposals do signal a clear intent to make a significant dent in regulatory burden in the future. The AMA will file comments on the proposed Fee Schedule rule in early September.

Independent Payment Advisory Board

A number of bills have been introduced to repeal the Independent Payment Advisory Board (IPAB). Although the controversial panel has never been formally appointed, the mandate to impose Medicare cuts through a fast-track process when total program spending exceeds a target amount remains. Although actuaries projected that recent Medicare spending trends would trigger the mandate in 2017, it did not happen this year. If it had been triggered, then provider payment rate cuts would have gone into effect in 2019 unless Congress acted. The AMA supports legislation to repeal the IPAB provisions of the Affordable Care Act, which has been introduced by Sens. John Cornyn (R-Texas) as S. 260, and Ron Wyden (D-Ore.) as S. 251. In the House, Reps. Phil Roe, MD (R-Tenn.) and Raul Ruiz (D-Calif.) introduced H.R. 849. We also submitted a statement for the record calling for IPAB repeal to the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health on July 20, 2017.

Diabetes Prevention Program (DPP)

Preventing type 2 diabetes is a major goal for the AMA and our partners. We received positive news toward this goal on July 10, 2017, when CMS released the 2018 Medicare Physician Fee Schedule (PFS) proposed rule. CMS proposes payment for the Medicare Diabetes Prevention Program (MDPP), with a maximum payment per beneficiary of $810 over three years for the set of MDPP core and maintenance sessions. CMS also proposes a two-year time limit on Medicare coverage for ongoing maintenance sessions. AMA comments on the previous CMS proposal had expressed concern that the proposed payment model was too restrictive in linking payments to patient adherence in attending sessions and health outcomes as measured by weight loss in a short period of time. The new proposal attempts to address these concerns by providing more flexibility to DPP providers in supporting patient engagement and attendance and by making performance-based payments available if patients meet weight-loss targets over a longer period of time. CMS also defers coverage for virtual programs to a CMMI demonstration, which has to be defined. CMS proposes to delay the start date of the MDPP for three months to April 1, 2018 from January 1, 2018. We will provide comments to CMS on the proposed rule expressing support for the
provisions that align with AMA objectives, and we will continue to offer suggestions to improve
the proposed rule on issues where we still have concerns.

At the state level, the AMA continues to advocate for insurance coverage of the DPP, including
through state Medicaid programs. This year, California enacted a budget bill allocating $5 million
from the state general fund to cover the DPP for Medicaid beneficiaries beginning on July 1, 2018.

**Insurer Mergers**

The AMA, with the help of 17 state medical association antitrust coalition partners from across the
country, achieved two huge victories in 2017 when federal trial court judges blocked these massive
insurance company mergers: the $37 billion Aetna-Humana merger and $54 billion Anthem-Cigna
merger. Soon after losing at trial, Aetna abandoned the merger. Anthem, though, appealed the trial
court judge’s decision to the U.S. Court of Appeals in Washington DC. On April 28, the federal
appeals court affirmed the trial court’s decision to block the Anthem-Cigna merger. Throughout the
appeal, the AMA and its coalition partners continued to vigorously oppose the Anthem-Cigna
merger. On May 12, Anthem dropped the merger.

At trial, Anthem’s own expert stated that this mega-merger would have reduced provider payments,
anually, by $2.4 billion. According to an analysis provided to the AMA, this $2.4 billion cut
included physician payment cuts of at least $500 million per year.

Our efforts to block the two mergers included:

- Utilizing the AMA’s updated gold standard Competition in Health Insurance: A
  Comprehensive Study of U.S. Markets;
- Preparing detailed state-specific market analysis of both the Anthem-Cigna and Aetna-Humana
  mergers;
- Sending comprehensive, evidence-based advocacy statements to the U.S. Department of
  Justice (DOJ) after the mergers were announced in July 2015 urging the DOJ to challenge both
  mergers;
- Leading a 17-state medical society coalition and engaging likeminded stakeholders, including
  the American Hospital Association and various patient coalitions;
- Testifying with the California Medical Association before the California Department of
  Insurance (DOI) opposing the Anthem-Cigna merger and filing a joint statement—the
  California DOI ended up opposing both mergers;
- Filing an evidenced-based advocacy letter with the Missouri DOI opposing the Aetna-Humana
  merger—the Missouri DOI later blocked the merger;
- Working closely with the Indiana State Medical Association, filed a statement with the Indiana
  DOI challenging the Anthem-Cigna merger;
- Supporting numerous other state medical associations in their efforts to oppose the mergers;
- Engaging the National Association of Attorneys General in an effort to convince key state AGs
  to join the DOJ in opposing the mergers;
- Conducting extensive physician surveys to gauge impact on patient care (in conjunction with
  the AMA’s state medical association partners);
- Marshaling nationally-recognized economists/legal experts in support of our arguments;
- Filing an amicus brief with the federal appeals court arguing against the Anthem/Cigna merger;
  and
- Facilitating another amicus brief from a group of nationally-renowned health care economists.
In response to these recent merger efforts and the potential for more proposed mergers, the AMA has developed a state level campaign to ensure fairness and transparency as states evaluate future merger proposals. It will also protect physicians from retaliation by health insurers.

**Opioid Epidemic**

The nation’s opioid epidemic continues to claim many lives, and according to the most recent Centers for Disease Control and Prevention data, deaths due to heroin and illicit fentanyl (12,957 and 9,549, respectively) outnumbered and were rising faster than deaths due to prescription opioids (12,728) in 2015. These numbers show that the nature of the epidemic is changing and that significant work still needs to be done to address the epidemic’s full scope. The rising mortality due to heroin and illicit fentanyl also makes it imperative to directly address the need for further treatment resources and access to treatment for patients who have an opioid use disorder.

In 2016, the AMA strongly supported federal legislation that recently led to $485 million being sent to states to help fund state-based treatment programs. We look forward to learning which efforts are most successful so we can build best practices throughout the nation. The AMA is also urging full funding of the Comprehensive Addiction and Recovery Act so even more resources will be available to fight the epidemic.

The AMA Opioid Task Force recently released its yearly progress report on physicians’ efforts to reverse the epidemic, showing:

- Physicians and other health care professionals queried their state prescription drug monitoring program (PDMP) more than 136 million times in 2016 – a 121 percent increase over 2014. Registration to use state PDMPs has nearly tripled since 2014 to more than 1.3 million registered users in 2016. Most state-specific increases occurred prior to new policies mandating PDMP use.
- More than 118,000 physicians accessed, attended or completed continuing medical educational and other courses offered by the AMA, American Osteopathic Association, and the American Dental Association and the nation’s state and specialty societies on safe opioid prescribing, pain management, addiction and related areas in 2015 and 2016.
- More than 37,000 physicians are now certified to provide office-based medication-assisted treatment for opioid use disorders across all 50 states – including more than 10,000 in the past year.
- While there remains work to do in ensuring comprehensive treatment for patients with pain, there was a national 17 percent decrease in opioid prescribing from 2012 to 2016 with decreases seen in every state. Nearly all decreases occurred prior to new state laws restricting the prescribing of opioids to certain dose and/or quantity limits.
- Nearly all 50 states have naloxone access laws, and in the first two months of 2017, more than 32,000 naloxone prescriptions were dispensed – a record 340 percent increase from 2016. Most of the new state laws were based, in part, on AMA model state legislation.

The AMA also created a new End the Opioid Epidemic Microsite to provide physicians with the state- and specialty-specific education and training to help end the nation’s opioid epidemic, the AMA—in concert with the Opioid Task Force—has identified nearly 300 resources for the new **AMA opioid microsite**. The resources are organized so that physicians and other health care professionals can access practical, relevant information about:
How PDMPs can help improve patient care;
• State- and specialty-specific information to ensure that physicians’ education is meaningful and relevant to their practice and patient population;
• Key resources to help improve pain management for acute and chronic, non-cancer pain;
• Becoming certified to provide in-office buprenorphine to patients with an opioid use disorder;
• Incorporating overdose prevention and treatment strategies in one’s practice;
• Practical information about naloxone;
• How to better talk with patients about safe storage and disposal of unwanted and unused opioid analgesics and all medications; and
• New research published in *JAMA*, and new resources developed by the Centers for Disease Control and Prevention, Substance Abuse and Mental Health Services Administration and other stakeholders.

**Prior Authorization**

The AMA has identified prior authorization as a major impediment for physicians as they seek to provide optimal care for their patients. In response, the AMA, in collaboration with a coalition of 16 other organizations representing physicians, hospitals, medical groups, pharmacists, and patients, released the Prior Authorization and Utilization Management Reform Principles in late January 2017. The 21 common sense principles form the foundation of a multi-pronged campaign to “right-size” health plan prior authorization and utilization management programs. More than 100 other provider and patient organizations have requested to be listed as supporters of the principles, and this number continues to grow. The principles have received extensive press coverage and have generated nearly 300 earned media citations.

The first wave of outreach on the principles to health plans, pharmacy benefit managers, and accreditation organizations has been very productive with mutual interest in this issue from many of these groups. Further, this advocacy is making an impact across the country. Just in the last year, at least eight states have enacted laws that limit prior authorization or step therapy, and insurers are starting to change their practices.

To further our efforts, the AMA partnered with the University of Southern California Schaeffer Center for Health Policy & Economics on an academic research project to assess the growing impact of prior authorization on physician practices and patients through analysis of Medicare claims data. This project has generated two manuscripts: the first provides a broad analysis of overall prior authorization trends and the effect of utilization management policies on medication use, while the second is a case study examining the impact of prior authorization for a specific class of drugs and disease state on patient outcomes and overall medical costs. Both manuscripts have been submitted for publication to peer-reviewed journals. The anticipated articles will strengthen and enhance the AMA’s advocacy on this issue.

**Pharmaceutical Cost Transparency**

Our recent work on the pharmaceutical cost issue stems from a series of resolutions at I-15 calling on the AMA to tackle spiking pharmaceutical costs and the detrimental effect this trend has on patients. In response, the AMA formed a task force in 2016 consisting of representatives of AMA policy councils, state medical associations, and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and adherence to medically necessary drug regimens. The task force discussed a variety of possible approaches, including Medicare drug price negotiation and re-importation, but ultimately recommended implementation of a grassroots campaign focused on increasing drug pricing.
transparency. This approach aligns with long-standing AMA policy encouraging prescription drug
price and cost transparency among pharmaceutical companies, pharmacy benefit managers (PBMs)
and health insurance companies.

To implement this campaign, the AMA launched an interactive grassroots campaign
microsite, TruthInRx.org, in November 2016 as the online hub for the AMA pharmaceutical
pricing transparency campaign, where patients can tell stories and activists can access further tools
and resources to make their voices heard with members of Congress and state legislators through
email and social media communications. We also created an online petition calling on
pharmaceutical companies, PBMs and health plans to be more transparent on pricing decisions.
The petition has been promoted through the AMA’s Patient Acton Network and other cause-
oriented websites (e.g., standunited.org and care2.org), and to date, over 154,000 people have
signed it. We are prepared to activate this group when federal legislation is introduced. Also, to
address this issue at the state level, the Board of Trustees recently approved a new model state bill
that would increase pharmaceutical price transparency and increase related areas for PBMs and
health plans. The model bill has been distributed to all 50 state medical associations and national
medical specialty societies, and the AMA will work with any interested society to advance this
legislation.

Network Adequacy/Out-of-Network Bills

Ensuring that provider networks offer access to timely, quality care continues to be a concern in
many states, as narrow networks become the norm and changes to networks take place throughout
the year. This continues to be a major area of focus for the AMA at the state level. This year,
Illinois was able to enact a comprehensive network adequacy bill that incorporated many
provisions of the AMA’s model bill. Also, Maryland, which enacted strong legislation last year that
also included many AMA model provisions, is now going through the regulatory process to
implement these positive changes. Draft regulations released earlier this year suggest Maryland
may end up with some of the strongest provider network requirements in the country.

State and specialty societies continue to work through legislative proposals with the AMA’s
guidance that would include prohibitions on anticipated out-of-network bills or “surprise” bills.
While some states proactively offered solutions that involved strong patient protections and fair
out-of-network payment to physicians, most states ended up fighting problematic bills that
undercut any incentives for insurers to offer physicians fair in-network contracts. In fact, more than
half of all states had at least one proposal this year on this topic, but only a handful ended up being
enacted. Bills in Arizona, Indiana, Louisiana, and New Hampshire focused largely on disclosure
and/or study committees. Texas expanded its current mediation process; while Maine and Oregon
enacted broader bans on out-of-network billing. A problematic bill passed both chambers in
Nevada, but was ultimately vetoed by the governor. The AMA sent a letter to Governor Brian
Sandoval supporting the Nevada State Medical Association effort to defeat the bill.

Physician-owned Hospitals

Currently, federal self-referral limitations effectively ban construction of physician-owned
hospitals and place restrictions on expansion of already-existing facilities. The Patient Access to
Higher Quality Health Care Act of 2017, introduced by Rep. Sam Johnson (R-TX) and Senator
James Lankford (R-OK) as H.R. 1156 and S. 113, respectively, would repeal these limits and level
the playing field for physician-owned hospitals allowing them to remain competitive and continue
their solid record of providing the highest quality health care to patients. The AMA is supporting
these bills based on our policy against this prohibition.
Medical Liability Reform

At the federal level, the AMA offered our support for the Protecting Access to Care Act of 2017 (PACA) (H.R. 1215). H.R. 1215 is a comprehensive medical liability reform bill that would help repair our nation’s liability system, reduce the growth of health care costs, and preserve patients’ access to medical care. The bill passed the House by a vote of 218 to 210. PACA provides the right balance of reforms by promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting noneconomic damages to a quarter million dollars. Importantly, H.R. 1215 includes language to protect medical liability reforms enacted at the state level. The CBO determined that H.R. 1215 would reduce federal health care spending by $44 billion over 10 years and reduce the deficit by $50 billion over the same period. At the time of this writing, PACA has not been acted on in the Senate.

The AMA continues to advocate for and defend medical liability reform at the state level as well. State legislatures in 2017 considered bills that promoted a variety of reforms, including expert witness guidelines, affidavit of merit requirements, collateral source reform and bills that establish structures such as pretrial screening panels or health court systems. A handful of states also considered and defeated attempts to raise caps on noneconomic damages. Iowa enacted a comprehensive bill that includes a $250,000 limit on noneconomic damages in most cases, stronger expert witness standards, a requirement for a certificate of merit in all medical liability lawsuits, and an expansion of the state’s previously passed communication and resolution framework. In addition, Arkansas’ legislature approved a ballot initiative proposing an amendment to the state constitution to limit damage awards and attorneys’ fees. Finally, Florida and Wisconsin both had disappointing judicial outcomes regarding their caps on noneconomic damages.

Team-based Care/Scope of Practice

State legislatures in 2017 considered over 750 bills seeking to eliminate team-based care models of health care delivery and/or expand the scope of practice of non-physician health care professionals. Though tough fights in all cases, most bills that threatened passage have been defeated with the support of the AMA and – as is often the case with scope bills – a coordinated state and specialty effort. State medical associations had particular success in defeating psychologist and naturopath prescribing legislation. In addition, the AMA and the Federation were largely successful in fending off the over 175 bills filed to expand the scope of practice of advanced practice nurses. For example, bills were defeated in Arkansas, California, Florida, Kentucky, Indiana, Mississippi, Missouri, Montana, Tennessee, Texas, and Virginia. The AMA continues to monitor state legislative activity on these and all other established and emerging scope of practice issues.

Telemedicine

The AMA actively negotiated with congressional staff and other major digital medicine stakeholders provisions of a recently introduced federal bill that would expand Medicare coverage of telehealth services. On May 3, 2017, S. 1016, the “Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2017” was introduced by Sen. Brian Schatz (D-HI). Subsequently, the companion bill, H.R. 2556 was introduced by Rep. Diane Black (R-TN) and Rep. Peter Welch (I-VT) on May 19, 2017. The legislation would expand Medicare coverage by removing a number of Medicare restrictions to coverage that are widely criticized as being antiquated including originating site restrictions that prevent delivery of telehealth to a beneficiary’s home as well as the geographic limitation which limits access to
telehealth services to rural locations, among a host of other provisions. The AMA secured changes from the draft versions to ensure: (1) state-based licensure requirements were retained; (2) telehealth was not used for Medicare Advantage network adequacy determinations; and (3) other provisions aligned closely with AMA policy. The AMA continues to work with various coalitions to advance this legislation as well as S. 870, the “Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017” which contains a number of provisions that parallel the CONNECT for Health Act provisions concerning waiver of Medicare restrictions for accountable care organizations, Medicare Advantage plans, telestroke, and home dialysis. On May 18, 2017, the U.S. Senate Finance Committee unanimously passed this bipartisan legislation. Moving forward, the AMA is actively working with Senate staff to craft another bill that would confer CMS with expanded waiver authority of current coverage restrictions conditioned on the CMS Chief Actuary certifying that the expansion would be cost neutral or costs saving in an effort to overcome Congressional Budget Office scoring obstacles that stymie passage of legislation that enjoys strong bipartisan support.

Following release of AMA model telemedicine legislation, states saw a flurry of activity in the area, with dozens of laws and regulations proposed to address telemedicine licensure, reimbursement, and practice standards. While most attention was given to debates over how to establish a patient-physician relationship via telemedicine – in person, face-to-face or over the phone – states continue to make gains in passage of coverage parity laws, ensuring that physicians will be compensated for treating their patients via telemedicine. Many of these laws were based on the AMA Telemedicine Act, which addresses these and other issues related to telemedicine.

Immigration/Travel Ban

The Trump administration’s executive order entitled “Protecting the Nation from Foreign Terrorist Entry into the United States” created significant uncertainty for the medical community and the ability to freely travel to the United States to either receive or provide care. The AMA swiftly reacted to this new policy by issuing letters to the Administration and Department of Homeland Security asking for clear exemptions for international medical graduates (IMGs), patients, and others who attend medical conferences or conduct medical research. In a joint letter with the Association of American Medical Colleges (AAMC), the AMA also noted the chilling effect this policy could have on foreign physicians entering the National Resident Matching Program (NRMP) or “Match,” and urged support for IMGs given the important role they play in providing care to rural and underserved areas. While the Supreme Court ruling clarified that students, residents, fellows, and lecturers should not be barred entry, the AMA continues to monitor the impact of the travel ban and seek greater exemptions for physicians and patients.

In addition, the AMA offered its support for S. 128, the “Bar Removal of Individuals who Dream and Grow our Economy Act” (BRIDGE Act), which would provide employment authorization and temporary relief from deportation for undocumented young immigrants who have Deferred Action for Childhood Arrivals (DACA) status. The AMA also worked to reinstate the premium processing of H-1B visas, which ensures that those in the Conrad 30 program can work in the United States without returning to their home country.

Graduate Medical Education (GME)

Congress has re-introduced GME legislation from previous sessions, entitled the Resident Physician Shortage Reduction Act (H.R. 2267/S.1301), which would create 15,000 additional Medicare-funded GME positions over five years. While this legislation appears promising, and the AMA has supported these bills, they are unlikely to be enacted given the significant cost and lack
of financial offsets. Instead, Congress continues to consider cuts to GME, especially indirect medical education (IME) payments. As a result, the AMA continues advocacy efforts to maintain and protect current GME funding levels. Thus far, the AMA has avoided any significant cuts to current federal funding and is working to continue to educate lawmakers about the need for greater support for GME.

In addition to supporting legislation in Congress to increase GME funding, the AMA has established an effective grassroots campaign to educate the public about the importance of GME. Our SaveGME website has generated significant public attention as well as media response targeted at policymakers. This website allows anyone interested in supporting GME to send letters to members of Congress in support of maintaining GME funding and increasing the number of Medicare-funded residency positions. The AMA has also drafted a compendium of GME policy alternatives. This resource can be used by legislators to consider innovative ways to increase GME funding and training positions. The AMA is also working with states to find other-payer solutions to GME funding. Examples of state laws that have been enacted include: Maryland established a tax credit for physicians or nurse practitioners who serve workforce shortage areas; Mississippi provided support for the creation of ACGME-accredited training programs based on a needs analysis of what residency programs might be necessary, while maintaining a strong and continued priority focus on family medicine; and West Virginia created a scholarship fund for medical students who commit to serve underserved areas of the state.

Conrad 30 Program

The Conrad 30 Program allows IMGs to remain in the United States in exchange for providing care in underserved areas. Currently, resident physicians from other countries working in the United States on J-1 visas are required to return to their home country after their residency has ended for two years before they can apply for another visa or green card. The Conrad 30 program allows these physicians to remain in the U.S. without having to return home if they agree to practice in an underserved area for three years. Many communities, including rural and low-income urban areas, have problems meeting their patient care needs and depend on the physicians in the Conrad 30 program to provide health care services. The program was set to expire this year if Congress did not act. On May 4, 2017, Congress passed an appropriations bill to fund the federal government through Fiscal Year 2017. This bill extended the Conrad 30 program through September 30, 2017. There is also bicameral legislation, S.898/HR. 2141 the “Conrad State 30 and Physician Access Reauthorization Act,” to extend the program for an additional three years. This bill would also make improvements to the program by requiring more transparency in employment contract terms and creating additional waivers per state. The AMA has issued support for this bill and is advocating for it to be passed by Congress.

Veterans Issues

The 115th Congress has held a number of hearings regarding the extension and improvement of the VA Choice program. The program was originally set to expire in August, 2017. In April, the President signed legislation to remove the sunset date and allow the program to continue to operate until those funds are expended. Recognizing that Congress was unlikely to act to reauthorize the program prior to the expiration of funding, the House in July passed additional legislation to provide more than $2 billion in interim funding for the VA Choice program. Congress is working its way through numerous issues as part of efforts to reauthorize the VA Choice program – including the consolidation of various VA purchased care programs, appropriate provider payment levels, the use of tiered networks and value-based reimbursement, the appropriate role of telemedicine, and the interoperability of electronic medical records. The AMA will continue to
work with the House and Senate Committees on Veterans Affairs to ensure that the emerging VA Choice reauthorization reflects the policy and priorities established by the HOD.

2017 AMPAC ACTIVITIES

AMPAC has once again worked closely with its state medical association PAC partners this election cycle on contribution support decisions for candidates running for the U.S. House of Representatives and Senate. A report summarizing AMPAC activities will be distributed at the Interim Meeting in Hawaii.

ADVOCACY RESEARCH

The AMA has also conducted/is conducting the following studies to assist in our efforts:

- The AMA will release an updated Economic Impact Study in December, 2017, which quantifies physicians’ economic impact on the state and national economies on four key economic indicators: economic output, jobs, wages and benefits and state and local tax revenue.
- This fall, the AMA published the 2017 Update to Competition in Health Insurance: A Comprehensive Study of U.S. Markets, its 16th edition of that work. This study provides detailed estimates of the degree of competition among health insurers in different markets. The study identifies areas where health insurer mergers may harm consumers and providers of care. Data from the two previous editions of the study were instrumental in AMA’s advocacy efforts that successfully blocked the Anthem-Cigna and Aetna-Humana proposed mergers.
- The AMA’s Physician Practice Benchmark Surveys, conducted in the fall of 2012, 2014, and 2016, provide nationally representative physician-level information that supports many of the AMA’s advocacy efforts. 2017 reports based on the Surveys focused on physicians’ practice arrangements (e.g., ownership and practice type and size); physicians’ patient-base and how the mix of patients was affected by the ACA; participation in accountable care organizations, medical homes and alternative payment models; and how frequently physicians are subject to medical liability claims.

CONCLUSION

This year has been a very successful one for the AMA on the advocacy front once again. We led the fight to protect coverage and access to quality, affordable health care for patients. We have made excellent strides on MACRA regulatory improvements, and the AMA is at the forefront of helping physicians to prepare for this transition. We also are continuing to make progress in reducing various regulatory burdens that hamper practice efficiency and contribute to physician burnout. Our collaborative effort with the Federation was vital to the defeat of the health insurer mega-mergers and stopped further insurer consolidation which would have had a host of negative effects. The AMA has also continued to make progress on public health issues such as halting the national opioid epidemic and helping physicians to provide resources to their patients at risk of developing diabetes. The AMA thanks our Federation partners for their collaboration and support, and we look forward to tackling medicine’s biggest issues again in 2018.
At the 2016 Interim Meeting, the House of Delegates (HOD) adopted Policy D-145.994, “Removing Restrictions on Federal Funding for Firearms Violence Research,” which called on our American Medical Association (AMA) to “provide an informational report on recent and current organizational actions taken on our existing AMA Policies (e.g., H-145.997) regarding removing the restrictions on federal funding for firearms violence research, with additional recommendations on any ongoing or proposed upcoming actions.” This report fulfills that directive.

BACKGROUND ON RESTRICTIONS ON FEDERAL FUNDING FOR FIREARMS VIOLENCE RESEARCH

Since the late 1990s, language has been inserted into either annual funding bills for the Departments of Labor, Health and Human Services, and Education or included into omnibus appropriations bills that has effectively limited federally-funded research related to firearm violence. Under the Public Health Service Act (PHSA), the Centers for Disease Control and Prevention (CDC), the lead public health agency for the federal government, is charged with conducting and providing grants for research “relating to the causes, mechanisms, prevention, diagnosis, treatment of injuries, and rehabilitation from injuries….” (42 U.S.C. § 280b(a)). From 1985 until 1996, the CDC’s National Center for Injury Prevention and Control (Injury Center) researched firearm violence or funded research that studied firearm violence as part of CDC’s statutory mandate. Many of these studies researched questions related to gun ownership and use. In 1993, after a CDC-funded study published in The New England Journal of Medicine concluded that guns in the home put people at greater risk of homicide, the National Rifle Association (NRA) argued that the CDC was advocating for gun control and that the Injury Center should be stripped of all funding.

Congress eventually decided to retain the Injury Center, but redirected $2.6 million (the exact amount spent on gun research the previous year) from its budget. Subsequently, in September 1996, Congress included a rider in the Omnibus Consolidated Appropriations Bill for Fiscal Year (“FY”) 1997 that stated that “none of the funds made available for injury prevention and control at the [CDC] may be used to advocate or promote gun control” (P.L. 104-208; September 30, 1996; 110 Stat. 3009, 3009-244). This language was sponsored by the late Representative Jay Dickey (R-AR) and is known as the Dickey Amendment or Rider. The Dickey amendment language has been included in each subsequent funding bill. Although in recent years such bills have rarely actually become law, the Dickey amendment has been included in the continuing resolutions or omnibus funding bills at the end of the year. For FY 2012, Congress expanded this limitation so that it applies to National Institutes of Health (NIH) funding as well. While attempts have been made to delete the amendment language, including in the immediate aftermath of the Charleston, South Carolina church shooting that killed nine people, such attempts have been rejected by appropriators.
While the Dickey amendment does not specifically prohibit research on the causes of firearm violence, for the past 20 years the language has had a chilling effect on the CDC. The Obama Administration maintained the position that research on the causes of firearm violence does not constitute “advocacy” and that such research would not be in violation of the Dickey amendment, and in fact directed the CDC to conduct such research. However, the CDC did not do so. According to a white paper prepared in August 2016 by the law firm of Covington & Burling LLP for the Law Center to Prevent Firearm violence, “CDC’s interpretation of the appropriations rider has had a dramatic effect on firearm research by effectively halting federally funded research on gun-related injuries. From 1996 to 2013, CDC funding for firearm injury prevention fell 96 percent.”

AMA ADVOCACY ACTIVITIES

AMA policy and advocacy activities have strongly urged Congress to take action on curbing firearm violence generally, and to allow and fund firearm violence research specifically. In April of 2016, the AMA, along with over 100 other medical organizations, sent a joint letter to Congress urging federal funding for research on firearm violence. In response to policy adopted at A-16 (D-145.995), the AMA issued a public statement that firearm violence represents a public health crisis that requires a comprehensive public health response and solution. That same policy directed the AMA to actively lobby Congress to lift the firearm violence research ban. Consequently, on June 15, 2016, the AMA sent a letter to the entire Senate advocating for federal support for research into the epidemiology of firearm violence and effective methods to reduce injury and death. Furthermore, the AMA continues to support two federal bills (S. 834 and H.R. 1832) that would authorize federal funds to the CDC for conducting or supporting research on firearm violence prevention.

AMA policy (H-145.975) also supports increased funding for the expansion of the National Violent Death Reporting System (NVDRS) to all 50 states and U.S. territories, to inform state and federal health policy. NVDRS is a state-based surveillance system that provides jurisdictions with a better understanding of violent deaths to guide decisions about violence prevention and track progress over time. In FY 2016, CDC received funding to expand NVDRS to a total of 42 jurisdictions. The FY 2017 omnibus appropriations bill provided level funding for NVDRS. Despite the fact that the FY 2018 President’s budget request for CDC was an estimated $1.2 billion (17 percent) below the FY 2017 continuing resolution level, the budget request maintained level funding for NVDRS.

In addition, AMA policy supports state research on firearm-related injuries and deaths (H-145.975). In the absence of federal funding for firearm violence research, at least one state has passed a budget that allocates funding for firearm violence research. In 2016, the California legislature allocated $5 million for the creation of a Firearm Violence Research Center at the University of California, Davis.

Policy was adopted at the 2016 Annual Meeting supporting a waiting period and background check for all firearm purchasers (H-145.996). As a result, the AMA endorsed a call to action on firearm-related injury and death in the U.S. issued in 2014 by eight medical organizations—including the American College of Physicians, the American Academy of Family Physicians, and the American Academy of Pediatrics—and the American Bar Association (ABA). More than 50 organizations have since endorsed the call to action, which includes a recommendation supporting federally-funded firearms research. On March 24, 2017, the AMA and the ABA, along with a number of local, state, and specialty medical societies, presented a program in Chicago on Preventing Firearm violence: Moving from Crisis to Action. The program explored a workable public health response to reducing firearm violence, including priorities for a research agenda.
The AMA continues to seek opportunities to advocate for federally-funded firearm violence research. The current leadership in Congress and the current Administration, however, oppose federal funding for such research. Thus, in the current political environment there is little expectation that federal legislation, such as S. 834 and H.R. 1832, could pass in Congress, or that the Administration would direct the CDC to conduct such research. Your Board has reviewed our extensive policy and believes that the AMA is well positioned to support any future legislative or regulatory proposals to provide funding for research, and to engage with other stakeholders to continue to educate policy leaders and the public that firearm violence remains a public health crisis and requires a comprehensive public health response and solution. Therefore, the Board is not recommending additional policy on this topic at this time.
At the 2016 Interim Meeting, the House of Delegates (HOD) adopted Policy D-355.996, “Limitations on Reports by Insurance Carriers to the National Practitioner Data Bank Unrelated to Patient Care,” with a progress report back at the 2017 Interim Meeting. This policy asks that:

Our AMA will seek legislation and/or regulation that would require the Health Resources and Services Administration (HRSA) to clarify that reports to the National Practitioner Data Bank (NPDB) of medical malpractice settlements by physicians be limited to those cases in which the named physician was directly involved in the provision of or failure to provide healthcare services.

Our AMA will seek legislation and/or regulation that would require HRSA to audit the NPDB for reports on physicians who were not involved in the treatment of a plaintiff, but were reported as a result of a healthcare entity’s settlement of a claim that included the names of those physicians in their administrative roles at the entity.

Our AMA will seek legislation and/or regulation that would require HRSA to remove reports from the NPDB of any physician who was reported as the result of the settlement of a claim by a healthcare entity where the physician was not involved in the treatment of the plaintiff.

Our AMA will provide a report to the House of Delegates at the 2017 Interim Meeting regarding our AMA’s interactions with HRSA and detailing the actions taken or planned by HRSA to eliminate inappropriate reporting of physicians to the NPDB.

In addition to this resolution, the HOD also adopted new policy at the 2017 Annual Meeting that directly relates to reporting on physicians who were not involved in treatment or patient care.

Policy H-355.976(7), “National Practitioner Data Bank,” states that:

Our AMA will: (a) request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (i) contingent upon competency or conduct related to the physicians’ provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (ii) only based on a professional review action and not for administrative or eligibility reasons; and (b) advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient.

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This report provides background on the NPDB, including its history and the integration of the Healthcare Integrity and Protection Data Bank into the NPDB; analyzes the reporting requirements in medical liability payments and medical staff appointments; highlights related AMA policy; and discusses AMA’s interactions with HRSA.

BACKGROUND: NATIONAL PRACTITIONER DATA BANK

The NPDB is a United States Government program that collects certain negative information on health care providers, including adverse licensure or clinical privileges actions, medical malpractice actions, and exclusion from participation in Medicare and Medicaid. The NPDB provides access to this negative information to only authorized users, such as hospitals and medical boards, but not the general public. The NPDB is managed by the Bureau of Health Workforce of the Health Resources and Services Administration in the U.S. Department of Health and Human Services.

History

The NPDB was created by Congress to restrict the ability of health care providers to move from state to state without disclosure or discovery of the provider’s previous disciplinary actions, licensure restrictions, or settled or adjudicated liability lawsuits. In addition, due to the threat of private money damages liability under federal laws, Congress wanted to provide incentives and protection for health care providers engaging in effective professional peer review.

The NPDB was established by the Health Care Quality Improvement Act of 1986 (HCQIA)\(^1\) and subsequent laws expanded the information collected and disclosed by the NPDB and modified its operations.

- Section 1921 of the Social Security Act\(^2\) authorizes the federal government to collect information concerning certain adverse licensure actions taken against any authority of the state responsible for the licensing of such practitioners or entities and reporting any negative action or finding that a state licensing authority, a peer review organization, or a private accreditation entity had taken against a health care practitioner or health care entity.
- Section 1128E of the Social Security Act\(^3\) established a national care fraud and abuse data collection program for the reporting and disclosing of certain final adverse actions taken against the health care provides. This data bank was known as the Healthcare Integrity and Protection Data Bank (HIPDB).
- Section 6403 of the Affordable Care Act\(^4\) amended sections 1128E and 1921 of the Social Security Act to eliminate duplication between the HIPDB and the NPDB. It also required the transferring of data collected in the HIPDB to the NPDB and to cease HIPDB operations. Information previously collected and disclosed by the HIPDB is now collected and disclosed by the NPDB. The transition of data from the HIPDB to the NPDB was completed in May 2013. This transition means that the NPDB jurisdiction is broader than its original intent and now includes all adverse actions from a medical licensing authority and any health care-related civil judgments or criminal convictions.\(^5\)

When a health care provider is subject of a NPDB report, the individual can—at any time—add a statement to the report or initiate a dispute. The statement becomes part of the report and remains with the report unless the individual edits or removes it. The statement is sent to the reporting entity, all queriers who received a copy of the report within the past three years, and is included in the future query responses.
An individual can also initiate a dispute and enter the report into “dispute status” to disagree with either the factual accuracy of the report or whether the report was submitted in accordance with NPDB requirements. Once in dispute status, the individual must contact the reporting entity and attempt to resolve the dispute directly. If the reporting entity fails to respond or responds unsatisfactorily, the individual can elevate the case to “dispute resolution.” In dispute resolution, HRSA will review and determine whether the information is accurate and reportable to the NPDB. If the information is inaccurate, HRSA will direct the reporting entity to revise or void the report.

While NPDB was established to improve health care quality, protect the public from incompetent providers, and reduce health care fraud and abuse, HRSA needs to provide clarification to stop unnecessary reporting to the NPDB when the physician’s conduct or competency in question is not related to the health or welfare of a patient. Unnecessary reporting is damaging to a physician’s reputation, employment status, hospital medical staff privileges, and future employment opportunities. Specifically, AMA policy shows concerns regarding unnecessary reporting of medical liability payments and medical staff appointment denials.

Reporting of Malpractice Payments

The NPDB requires medical malpractice payers to report medical malpractice payments. The payment is for the benefit of a health care provider in settlement of a written claim or judgment for medical malpractice against that practitioner. A payment made as a result of a suit or claim solely against an entity (e.g., hospital) that does not identify an individual practitioner should not be reported to the NPDB. Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. A medical malpractice payer also reports a supervisory practitioner that is named in a complaint based on the actions of a subordinate practitioner (e.g., resident, student).

The written complaint or claim must be based on a provider’s provision of or failure to provide health care services. However, the NPDB statute, regulation, guidebook, or FAQs do not further define “provision of or failure to provide health care services.” Without any further clarification from HRSA, malpractice payers are reporting instances to the NPDB where the physician serves in an administrative only capacity and has no direct contact or relationship with the plaintiff that is demanding payment. In these instances, physicians are not providing health care services or failing to provide health care services. Therefore, these payments should not be reported to the NPDB because NPDB’s statutes and regulations limit the filing of medical malpractice reports based on whether a physician provided or failed to provide health care services.

Reporting Medical Staff Appointment Denials

The NPDB requires hospitals and other health care entities to report adverse clinical privileges actions. An adverse action includes any professional review action that adversely affects the clinical privileges of a physician for a period of more than 30 days. It also includes the acceptance of the surrender or restriction of clinical privileges while the physician is under investigation relating to possible incompetence or unprofessional conduct or when the surrender occurs in lieu of conducting an investigation. Clinical privileges include privileges, medical staff membership, and other circumstances in which a physician is permitted to furnish medical care by a health care entity. Thus, a medical staff denial is a type of clinical privilege.

Adverse clinical privileges actions are based on a physician’s competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Whether an action affects or could affect patient health or welfare is generally a determination that must be
made by the hospital or other entity taking the action. If, in the opinion of the entity, the provider’s actions could adversely affect the health or welfare of a patient, and the action is the result of a professional review, the action must be reported to the NPDB. Potential actions include lying on an application, not completing medical records, outbursts of anger, throwing charts and instruments in the operating room, and cutting and pasting notes and lab results from one patient’s electronic health record (EHR) to another patient’s EHR.

Administrative actions that do not involve a professional review action should not be reported to the NPDB. Thus, if an individual is denied clinical privileges because the individual failed to meet a hospital’s established threshold criteria (e.g., board certification), the hospital should not report this action to the NPDB. Furthermore, matters not related to the professional competence or professional conduct of a practitioner should not be reported. For example, adverse actions based primarily on a practitioner’s advertising practices, fee structure, salary arrangement, affiliation with other associations or health care professionals, or other competitive acts intended to solicit or retain business are excluded from NPDB reporting requirements.

While the NPDB Guidebook states that actions that do not involve a professional review action should not be reported, physicians are still being reported based on administrative and eligibility reviews. HRSA needs to provide further clarification as to what constitutes a professional review action and what constitutes an administrative or eligibility-based action. In addition, although HRSA states that it is the opinion of the reporting entity as to whether an action affects or could affect patient health or welfare, it would be beneficial to both reporting entities and health care providers to state factors that a hospital should consider in making this determination.

AMA OUTREACH WITH HRSA

AMA has consistently reached out to HRSA involving the NPDB, including proposed rule and guidebook comments. Because of the duplicative reports and often misleading information that can be found in the NPDB, previous correspondence has helped ensure that the NPDB remains unavailable for public access. Moreover, AMA’s comments on the draft guidebook ensured that censures, reprimands, or admonishments are not reported to the NPDB. Furthermore, AMA advocacy led to inclusion of the following language in the 2015 revision to the NPDB guidebook: “Medical malpractice payments are limited to exchanges of money and must be the result of a written complaint or claim demanding monetary payment for damages. The written complaint or claim must be based on a practitioner’s provision of or failure to provide health care services.”

In August 2017, the AMA sent a letter to HRSA seeking clarification regarding malpractice payments and medical staff appointment denials and reiterating concerns surrounding the surrendering of clinical privileges while a provider is unaware of an ongoing investigation. The letter also requests a meeting between AMA and HRSA to discuss these issues. While Policy D-355.996 suggests that the AMA also seek potential legislation, advocating for a legislative change would provide an opportunity for some members of Congress and other groups to open the NPDB to the general public. Your Board believes a more prudent and practical approach is to continue to work with HRSA to provide the necessary clarifications for reporting to the NPDB.

CONCLUSION

As of the date this report was drafted, HRSA has not responded to AMA’s request for a meeting. The AMA will continue to urge HRSA to provide clarification and potentially remove individuals who were improperly reported to the NPDB.
REFERENCES

1 42 U.S.C. 11101 et seq.
2 Section 1921 of the Social Security Act as amended by section 5(b) of the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100–93, and as amended by the Omnibus Budget Reconciliation Act of 1990, Public Law 101–508.
4 Section 6403 of the Patient Protection and Affordable Care Act of 2010, Public Law 111–148.
7 Comment Letter from AMA to HRSA, Notice of Proposed Rulemaking Concerning Privacy Act; Exempt Record System, Apr. 18, 2011; Letter from AMA to HRSA; The National Practitioner Data Bank Public Data File, Sept. 23, 2011; Comment Letter from AMA to HRSA, Elimination of Duplication Between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank, Apr. 16, 2012; Comment Letter from AMA to HRSA, Draft Revised Guidebook for the National Practitioner Data Bank; Jan. 31, 2014; Comment Letter from AMA to HRSA, National Practitioner Data Bank Surrendering of Privileges, Nov. 8, 2016.
8 Letter from AMA to HRSA, NPDB Clarification on Medical Malpractice Payments and Adverse Clinical Privileges Actions, August 3, 2017.

APPENDIX – CURRENT AMA POLICY

Policy H-355.976, “National Practitioner Data Bank”

1. Our AMA believes that (A) the National Practitioner Data Bank requirements should be modified so that settlements and judgments of less than $30,000 are not reported or recorded; (B) reports, other than licensure revocation, in the Data Bank should be purged after five years; (C) proctoring of physicians for the purpose of investigation should not be reportable; (D) physicians should not be required to turn over copies of their Data Bank file to anyone not authorized direct access to the Data Bank; and (E) any physician’s statement included in the Data Bank file should automatically accompany any adverse report about that physician in distributions from the Data Bank.

2. Our AMA will (a) work with HHS to establish a mechanism to inform physicians when an inquiry to the Data Bank has been made; and (b) support efforts to require the same Data Bank reporting requirements for physicians, dentists and other licensed health care practitioners.

3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee.

4. Our AMA supports using all necessary efforts to direct the National Practitioner Data Bank to send all notifications to physicians by certified mail return receipt requested, and supports using all necessary efforts at the federal level to direct the National Practitioner Data Bank to begin the sixty day appeal process from the date the physician receives notification.

5. Our AMA will work with the appropriate federal agencies to ensure that the National Practitioner Data Bank reflects all disciplinary actions on appeal, and to remove from the physician’s record reported decisions which have been overruled.

6. Our AMA will continue to monitor the issue of reporting impaired physicians to the National Practitioner Data Bank and will seek further clarification of ambiguities or misinterpretations of the reporting requirements for impaired physicians.

7. Our AMA will: (a) request that the Health Resources and Services Administration (HRSA) clarify that reports of medical staff appointment denial of physicians be (i) contingent upon competency or conduct related to the physicians’ provision of or failure to provide healthcare services that adversely affect the health or welfare of a patient, and (ii) only based on a professional review action and not for administrative or eligibility reasons; and (b) advocate that HRSA remove the name of any physician from the National Practitioner Data Bank reported for reasons not related to competence or conduct that adversely affected the health or welfare of a patient.
Policy H-355.975, “Opposition to the National Practitioner Data Bank”
1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank.
2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank.
3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office.
4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank.
5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;
6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least $30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.
8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates.

Policy H-355.990, “National Practitioner Data Bank”
(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB).
(2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner’s self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than $30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB’s first year of operation to the AMA by July 1992.
(3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.
Policy H-355.974, “National Practitioner Data Bank”
1. Our AMA will advocate to the Health Resources and Services Administration that a physician’s surrender of clinical privileges or failure to renew clinical privileges while under investigation should not be reported to the National Practitioner Data Bank unless the physician has been notified that an investigation is underway.
2. Our AMA: (a) recommends that medical staff bylaws require that physicians be notified in writing prior to the start of any investigation; and (b) include this recommendation in our AMA Physician’s Guide to Medical Staff Organization Bylaws.
Our AMA continues to execute its multi-year strategy to achieve significant positive impact for physicians, medical students and patients. The strategy, launched in 2013, identified three areas of emphasis in our mission focused areas: Improving Health Outcomes, Accelerating Change in Medical Education, and Shaping Care Delivery and Payment for Professional Satisfaction and Practice. These focus areas provide for tangible and meaningful implementation of our AMA’s mission to promote the art and science of medicine and the betterment of public health.

Through this report, the Board of Trustees affirms AMA’s multi-year strategic focus. This report is devoted to what is on the horizon for each of the focus areas in 2018 and highlights other work to modernize the means through which physicians can engage in advancement of the mission.

CARE DELIVERY AND PAYMENT:
PROFESSIONAL SATISFACTION AND PRACTICE SUSTAINABILITY

With the successful repeal of the sustainable growth rate (SGR) in 2015 through the Medicare and CHIP Reauthorization Act of 2015 (MACRA), our work has refocused—with even greater intensity—to ensure that MACRA’s implementation supports a health care system that delivers better care and more visible value while also supporting a sustainable and professionally satisfying practice environment. The goal is to create a pathway for physicians to choose from a broad array of alternative payment and health care delivery models, including viable fee-for-service options.

Successful navigation and implementation of evolving public and private payment systems requires heightened physician awareness, informed assessment of options, and, potentially, new strategic and operating methods to optimize success. To support physicians through this changing landscape and improve care delivery and professional satisfaction, AMA will work in 2018 to:

- Advocate for legislative and regulatory changes that enhance prospects for physicians to succeed.
- Generate awareness and encourage physicians to prepare for evolving payment model changes.
- Provide multi-modal, multi-channel physician education about what new payment model options mean for physicians and patients.
- Guide physicians toward the best outcome in value-based care systems and establish the AMA as a valued source of support on issues spanning a wide range of care delivery and payment models.
- Expand the resources delivered through the STEPS Forward: Practice Improvement Strategies program and other tools to help physicians in a variety of practice settings learn new techniques to improve practice workflow, patient care and professional satisfaction.
- Increase the awareness and importance of professional satisfaction and support the Quadruple Aim through additional research, partnerships, and resources to assist physicians throughout the various settings and stages of their careers.
- Discover and promote the physician perspective across health technology sectors, directing development for improved usability, productive access to data, and respect for the patient-physician relationship.
In addition taking the longer perspective in 2018 AMA will build on its 2017 research and development work to further assess opportunities for diagnostic, prognostic, and predictive tools for patient care that will modernize health and medical information systems to give physicians access to data needed for enhanced clinical, operational, and administrative effectiveness.

**IMPROVING HEALTH OUTCOMES (IHO)**

Initiatives focused on health outcomes, particularly in the area of prevention and management of chronic care, underscore AMA’s foundational commitment to improving the health of the nation. Concentrating on risk factors for cardiovascular disease and type 2 diabetes, our AMA is working with physicians and care teams to bring new approaches for anticipating, preventing, and managing widely prevalent chronic conditions.

To achieve the scale required for this ambitious set of programs, AMA has developed multi-year strategic relationships with the Centers for Disease Control and Prevention (CDC) and the American Heart Association (AHA), whose national reach and influence reinforce and complement AMA resources. Our shared goals with the CDC and the AHA include significantly increasing the number of physician practices, health care systems and federally qualified health centers that:

- Screen patients for prediabetes and refer eligible patients to CDC-recognized diabetes prevention programs (DPPs) as the preferred option for preventing type 2 diabetes, and
- Improve care for patients with hypertension to achieve and sustain 70 percent or higher blood pressure control rates within the communities they serve.

AMA’s partnerships with the CDC and AHA are solid and we are complementing them with collaborations with medical societies, business groups, payers, technology companies, and medical schools (through the ACE consortium) to offer evidence-based products, tools and services to support physicians, care teams, health system leaders and medical students in achieving the health outcomes we seek. Materials have been developed and distributed for use in practice settings ranging from small private practices to large integrated systems. The material and programs have been empirically demonstrated to be effective and our main focus is to create the environmental, distribution, and awareness elements conducive to wide spread scaling. In this regard, we continue to define and promote the “business case” for public and private payer coverage of proven interventions such as diabetes prevention programs (for which Medicare announced coverage in 2016) and self-measured blood pressure monitoring devices.

Public and physician awareness is a key ingredient to success. Beginning in 2017 and extending through 2018, we will refresh the successful pre-diabetes public campaign launched in 2016 and add a physician oriented pre-diabetes awareness campaign. A blood pressure awareness program is planned for 2018.

**ACCELERATING CHANGE IN MEDICAL EDUCATION (ACE)**

Since 2013 the AMA has supported a Consortium of medical schools, now 32 in number, to accelerate change in medical education by creating a system that trains physicians to meet the needs of today's patients and to anticipate future changes. Facilitated by the AMA through individual and collaborative work the consortium schools have created new and innovative programs and technologies that are increasingly adopted by medical schools throughout the nation. Of particular note is the successful application of the chronic care curriculum based on work done in our Improving Health Outcomes area. This is an example of the growing application of work emanating from one strategic area to another critical arena.
Highlights of major plans for 2018 include:
• Ensuring the ongoing viability and maintenance of the Consortium beyond the termination of the AMA funding cycle.
• Building on the AMA Consortium health system science textbook to create a product and service line applicable to all stages of physician and other health care providers’ lifelong learning.
• Collaborating with other focus areas on student and trainee wellness; resilience/burnout; and new models for linking students, physicians and communities in shared goals of chronic disease management and health equity.
• Based on the experience and learning from the work in undergraduate medical education, plans will be developed for subsequent work in graduate medical education likely emphasizing the transition from undergraduate to residency status.

ENGAGING PHYSICIANS IN ADVANCEMENT OF THE MISSION

Effective and responsive lifelong physician professional development is a cornerstone to activating the focus area objectives. These objectives and other national imperatives—such as reducing opioid-related harm and increasing access to treatment for patients with opioid use disorders, responding to physician burnout and wellness issues, responding to the quality and cost issues in our health care environment—require AMA to provide physicians and their team members pragmatic educational offerings, tools, and leadership training designed to address real-world practice and care delivery issues.

The AMA’s Education Center portal and platform is a crucial component of AMA’s commitment to lifelong professional development. New capabilities and an improved user experience were introduced in 2017. The GME Competency Education Program (formerly Introduction to the Practice of Medicine), currently deployed in approximately 150 residency settings across the country, was modernized and incorporated into the Education Center in 2017. As the multi-year effort progresses, our physician stakeholders will have access to educational tools and resources from diverse sources through a highly functional platform tailored to individual needs, accessible from desktops and mobile devices, with streamlined support for transcripts, reporting to boards, employers and payers to serve credentialing, licensing and certification requirements. We anticipate completing the majority of the Education Center refresh in 2018.

Evidence of AMA mission impact continues to grow, creating an opportunity for AMA to refresh its brand identify among physicians and other stakeholders. We will achieve this by linking relevant offerings and activities throughout the career lifecycle of students, residents, and practicing physicians and more refined approaches to identifying and responding to the particular interests and needs of the physician population. The goal is to strengthen the AMA brand through deeper stakeholder engagement. Traditional and interactive/social/digital media will be deployed to create new connections, awareness, and opportunities to interact with the AMA. More sophisticated monitoring of interactions also will yield insight into physician preferences so that we can continuously improve services to physicians, residents and fellows, and medical students so as to retain and grow our membership base. In 2018 we will build on our initial experience with social networks and community groups started in 2017 by further refined exploration and integration of this strategy into our overall physician engagement effort.

The three focus areas have made much progress since their inception in 2013. As they have matured and moved from the early stages of innovation and learning to more operative models of impact and scaling we have begun to extend the conceptualization and connection of their work to other important aspects of our AMA’s efforts under three general strategic arcs: 1) Vital practice resources; 2) Lifelong professional development; and 3) Improving the health of nation. Closer connection of the focus areas with other critical AMA activities will stimulate more collaborative and synergistic planning and operations enhancing our effectiveness and impact.
The momentum that supports this multi-year strategy is a reflection of collaboration and shared commitment across the AMA and the Federation of medicine, academic institutions, public and private health sector organizations, technology innovators, physicians, and physicians in training. Together we will chart a course for health care delivery that will improve the health of the nation.
REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-I-17

Subject: Parental Leave

Presented by: Gerald E. Harmon, MD, Chair

INTRODUCTION

At the 2016 Interim Meeting of the House of Delegates (HOD), Policy H-405.954, “Parental Leave,” was adopted. The policy states the American Medical Association (AMA) will: (1) encourage the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA) (a) a reduction in the number of employees from 50 employees; (b) an increase in the number of covered weeks from 12 weeks; (c) creating a new benefit of paid parental leave; and (2) study the effects of FMLA expansion on physicians in varied practice environments. This report serves as a summary of the FMLA, proposed expansion of the law and potential for study of the effects of future expansion, with a focus on the effects on physicians.

BACKGROUND

The FMLA provides certain employees with up to 12 weeks of unpaid, job-protected leave per year. Eligible beneficiaries of FMLA include employees who have been employed by their employer at least 12 months, worked at least 1,250 hours over the past 12 months, and work at a location where the company employs 50 or more employees within 75 miles. Private employers with at least 50 employees (employed for at least 20 weeks in the preceding or current calendar year) and public employers with any number of employees are covered by the FMLA.1 Several proposals for expansion of the FMLA at the federal level have been considered. Expansion of employee eligibility, covered leave time or employer requirements would undoubtedly result in various impacts on employees and employers,2 including physicians who are employed or employ others. Another proposed form of expansion, the creation of a required paid parental leave benefit, would also have significant implications for employers, employees, and new parents and infants.3-6

AMA POLICY

AMA policy supports voluntary employer policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave becomes necessary due to documented medical conditions (Policy H-420.979). The AMA recognizes the public health benefits of paid sick leave and other paid time off, although mandatory paid sick leave is not specifically endorsed by the AMA. Council on Medical Service Report (CMS) 3-A-16 provided a comprehensive review of sick leave and paid leave policies. The HOD adopted the recommendations in the report that established policy supporting employer policies that provide employees with unpaid sick days to care for themselves or a family member (Policy H-440.823). The AMA recognizes that physicians, as employees and employers, are impacted by the FMLA and other medical leave regulations. AMA Policies for Parental, Family and Medical Necessity

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Leave (Policy H-405.960) established guidelines that encourage medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician’s standard benefit agreement. This policy also encourages staff scheduling to allow for coverage during a physician’s leave without creating intolerable increases in other physicians’ workloads, particularly in residency programs, and that physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.

DISCUSSION

Expansion of the FMLA

Proposals to expand the FMLA have been presented by legislators and advocacy organizations who assert that the U.S. lags behind other industrialized nations in its existing laws related to employee leave. On the federal level, proposals for expansion have attempted to:

1. expand employee eligibility by removing the 1,250 hour requirement, eliminating the requirement that an employee work for the employer for at least 12 months, or lowering the employer threshold of 50 employees within 75 miles;
2. cover more employers by including those with 15 or 25 employees;
3. increase the number of covered weeks; and
4. establish a mandated paid leave benefit.

One proposed federal expansion law is the Family and Medical Insurance Leave Act (the FAMILY Act) S. 337/H.R. 947, which would, among other things:

- create a national program to provide all workers, regardless of company size, with up to 12 weeks of partially paid leave; and
- enable workers to receive up to 66 percent of their monthly wages, up to a capped amount, during their time of leave.

Many states have already enacted laws that provide benefits in excess of those provided under the FMLA. Currently, three states—California, New Jersey and Rhode Island—have required paid family leave. New York will be the fourth in 2018 when its Paid Family Leave Benefits Law will be effective. Additionally, five states and several cities have implemented paid sick leave laws. The laws in these cities and states go beyond the required unpaid leave of the FMLA to provide employees with guaranteed pay during various types of approved medical leave. Benefits to both employees and employers have been reported in the states providing paid family leave.

In California, for example, the Paid Family Leave program provides employees with up to six weeks of paid leave to care for a new child or ill family member. The program is funded by employee payroll contributions, so while employers do not face financial burden as a result of the law, they are faced with ensuring the employees’ workload is covered and that gaps in staffing are filled. The program in California, however, does not assure job protection during leave, provides wage replacement at only 55 percent, and does not cover care for grandparents, grandchildren, parents-in-law, or siblings. A 10-year review of California’s expansion demonstrated that the Paid Family Leave benefit promoted family well-being, improved family economic security, equalized access to leave across occupations and income levels, and bolstered businesses by reducing workforce turnover. It was also noted that overall awareness of the program among those most likely to utilize it was low, implying that utilization rates could be higher if education and outreach were improved upon. Similar outcomes have been reported for other cities and states.8-10
Existing Research

There is an abundance of literature about the benefits of employee access to medical leave provided under existing law, much of which was summarized in CMS Report 3-A-16. For example, studies show that children recover faster from illness when cared for by a parent, and the presence of a parent has been shown to reduce hospital stay duration by 31 percent. A national health impact assessment demonstrated that paid sick leave policy would result in more workers taking needed leave to recover from illness, receive preventive care, and care for ill children. These actions would reduce transmission of influenza, foodborne disease, and gastrointestinal infections in health care facilities. Some proponents of paid sick leave policies claim companies can experience cost savings, increased productivity, and disease and illness prevention when employees are able to take time off when they or a family member are ill.

In addition to evidence showing the benefits of leave policies, lack of paid sick leave can have significant and adverse effects on public health. Workers without paid sick leave are more likely to work while ill and delay medical care, which can lead to prolonged illness and likeliness of worsening otherwise minor health issues. One study revealed that lack of workplace policies, such as paid sick leave, was correlated with a higher incidence of influenza-like illness. A 2007 study estimated that the annual flu season results in over 3 million hospitalized days and costs employers $10.4 billion in direct medical costs for hospitalizations and outpatient visits.

Also outlined in CMS Report 3-A-16 are the concerns employers and employer groups have expressed with the prospect of expanding medical leave benefits. Some employer groups oppose expanding FMLA benefits due to the potential for increased costs. Others claim paid leave policies or policies that provide coverage for more employees may burden and negatively impact employer operations, with hospitals and physician practices being no exception.

Although it is limited, research does exist that demonstrates projected effects of various types of expansion upon family leave policies. An analysis published by IMPAQ International, Inc. and the Institute for Women’s Policy Research summarizes a simulation of five paid family and medical leave model programs based on working programs in three states and a federal proposal, all applied to the national workforce. The findings suggest that upon expansion of FMLA laws, through covering more eligible workers, replacing a larger percentage of usual earnings, and offering more weeks of paid leave increase the estimated costs. If based on any of the five models in the simulation, the cost for benefits would range from $31 billion to $43 billion. This report also projects that a national paid family and medical leave policy, depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent annually.

Another report by the Institute for Women’s Policy Research estimates costs for a series of policy scenarios for employers in New Hampshire. Using a simulation model, the authors estimated the total program costs for the Family Medical Leave Insurance (FMLI) policy proposal if the law was changed to require all employers to provide benefits, only firms with 25 or more employees, and only firms with 50 or more (current policy). The total costs were estimated at $163.5 million when all employees are covered, $133.8 million when only firms with 25 or more employees are covered, and $124.1 million when only firms with 50 or more employees are covered. In addition to the cost implications of covering more employees, the authors projected an increase in the number of leaves taken and a decrease in the average weekly benefit. Similar research has been reported for the District of Columbia.
Implications for Physicians

Expansion of FMLA benefits to include more employers or employees would undoubtedly affect physicians who employ others or are employed. Upon any form of expansion of FMLA, physicians who employ others and physicians in small practices would be expected to experience some changes in the operations of their practices. In 2016, 37.9 percent of U.S. physicians worked in practices with less than five physicians, 19.9 percent in practices with five to 10 physicians, and 13.3 percent with 11 to 24 physicians.

<table>
<thead>
<tr>
<th>Number of physicians in practice</th>
<th>Distribution of physicians by practice size</th>
<th>Estimated full-time employee count</th>
<th>Affected by expansion in FMLA coverage from 50 to 25 minimum FTE</th>
<th>Affected by expansion in FMLA coverage to ALL employees</th>
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<tr>
<td>1-4</td>
<td>37.9%</td>
<td>5-20</td>
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<tr>
<td>5-10</td>
<td>19.9%</td>
<td>25-50</td>
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<tr>
<td>11-24</td>
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<td>No</td>
</tr>
<tr>
<td>50+</td>
<td>13.8%</td>
<td>250+</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

*Number of full-time staff members per physician varies according to specialty, practice setting and other factors. This full-time employee count assumes an average of four full-time staff members per full-time physician and includes the physician.

As of 2016, most physicians (57.8 percent) work in practices with 10 or fewer physicians. Given there is an average of four full time support staff for every full-time practicing physician, it would likely be the practices with 10 or fewer physicians that would be impacted by any reduction in the threshold to include more employees under FMLA. (Those with 11 or more physicians are already likely covered under current legislation.) For example, if FMLA coverage were expanded to include employers with 25 or more employees, or all employers regardless of size, these practices with 10 or fewer physicians may be required to make changes in scheduling, staffing processes or other aspects of practice operations. Reports on business’ experiences with FMLA compliance are limited and mixed, suggesting that these changes could be burdensome for some practices, but may pose no issues for others. One survey concluded employers report little negative impact of complying with FMLA, but another report indicates a high number of complaints about the record keeping and coordination of state and federal leave policies.

A study conducted by the National Federation of Independent Business (NFIB) used a regulatory impact model to calculate the projected costs of an expanded FMLA leave program on small businesses. Their findings showed small businesses would be faced with an additional cost of approximately $30,000 to $50,000 in reduced sales, mandatory overtime payments, and diversion of management attention. This study focused on manufacturing, construction, and various service industries and did not include data for health care employers; therefore, assuming correlations that suggest similar impacts in health care settings is cautioned against.

As outlined in the previously mentioned reports, the effects on employees, including physicians, would be dependent on many factors including practice size and whether expansion of the law would change the employer’s existing coverage. As more and more physicians move from solo or small practices to employment within health systems or hospitals, some may gain coverage under FMLA law. The personal effects of FMLA expansion on physicians would likely be similar to the
overall public health benefits described earlier in this report and in CMS Report 3-A-16. There is no research or literature to suggest that physicians employed by organizations subjected to expanded FMLA requirements would experience benefits that are significantly different than those experienced by employees in other professions.

CONCLUSION

Our review of existing research has demonstrated that expansion of FMLA laws could increase the cost of benefits to employers. Depending on the type of expansion, the costs could range from $31 billion to $43 billion. A national paid family and medical leave policy, depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent annually. Finally, any expansion of FMLA coverage would likely predominantly affect physician practices with 10 or fewer physicians.

The first directive in Policy H-405.954 states the AMA will encourage the study of the health implications among patients if the FMLA law was modified. The AMA recognizes the importance of effects changes in the law may have on patient outcomes. In addition to the federal law, states may have, or may enact in the future, any variety of family leave laws that provide benefits to more employees. Patient demographics and health care needs also vary across states and regions. It is for these reasons that the AMA will continue ongoing collaborations with state medical societies to observe and track the variety of local and state family leave laws and study the related health implications for patients.

The second directive of Policy H-405.954 states the AMA will study the effects of FMLA expansion on physicians. Upon enactment of federal laws that provide more expansive coverage or coverage to a larger number of people, there should be opportunities to study the effects on physicians and health care employers more expansively than the simulations discussed herein.

The AMA recognizes the importance and benefits of access to medical and family leave, and existing policies H-420.979 and H-405.960 are demonstrative of this cognizance. While the AMA does not endorse policies requiring paid leave, it does encourage medical group practices to incorporate leave policies, including parental, family, and medical leave policies, in their standard benefit structure.
REFERENCES


INTRODUCTION

At the 2017 Annual Meeting, the American Medical Association House of Delegates adopted the recommendations of Council on Ethical and Judicial Affairs Report 1-A-17, “Amendment to E-2.3.2, Professionalism in Social Media.” The Council issues this Opinion, which will appear in the next version of AMA PolicyFinder and the next print edition of the Code of Medical Ethics.

E-2.3.2 Professionalism in Social Media

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar opportunities can support physicians’ personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunities to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

(a) Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

(b) When using social media for educational purposes or to exchange information professionally with other physicians, follow ethics guidance regarding confidentiality, privacy and informed consent.

(c) When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.
(d) If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethics guidance just as they would in any other context.

(e) To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

(f) When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.

(g) Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession. (I, II, IV)
Subject: A National Continuing Medical Education Repository

Presented by: Lynne M. Kirk, MD, Chair

It is a physician’s professional responsibility to participate in continuing medical education (CME) activities in order to sustain life-long learning and improve the care provided to patients. Often, CME credits can be used to meet the CME requirements of state medical and osteopathic boards, medical specialty societies, specialty boards, hospital medical staffs, and insurance networks. Yet the tools with which physicians track their CME vary widely by state, specialty, and institution.

In a previous report, the American Medical Association (AMA) Council on Medical Education noted that while a central repository/online reporting system that would allow a physician to track/store CME credits would be very useful for meeting requirements for licensure, certification, and credentialing, many specialty and state medical societies and other organizations already provide such services, and a central repository was perceived as duplicative (or not warranted). Additionally, research indicated that the cost of a centralized service would almost invariably be borne by physicians. Furthermore, all CME providers would need to agree upon technical and data security proposals in order to proceed with a centralized repository, and questions about which entity(ies) would fund and maintain such a service remained unanswered. Pursuant to more recent Council on Medical Education discussions, however, members agreed that a follow-up review was warranted, given the time elapsed since the adoption of the previous report.

BACKGROUND

There are three major credit systems in the United States: (1) The AMA Physician Recognition Award (PRA) credit system; (2) American Academy of Family Physicians (AAFP) credit system; and (3) American Osteopathic Association (AOA) credit system. These three established credit systems facilitate physician credentialing and the renewal of licensure by providing metrics to demonstrate that a physician has maintained a commitment to study, apply, and advance scientific knowledge through participation in appropriate CME activities. There is strong communication and cooperation among the AMA, AOA, and AAFP, and although there are differences in how credits are categorized, the CME rules followed are similar in many ways. However, there is no centralized data repository to track all CME credits earned by a physician, and physicians are generally personally responsible for tracking and documenting their earned CME credits when verification is required for licensure or other credentialing purposes.

CREDIT SYSTEMS AND ACCREDITING BODIES

AMA, ACCME, and State/Territory Medical Societies

In 2016, more than 1,800 CME providers accredited by the Accreditation Council for Continuing Medical Education (ACCME) and state/territory medical societies produced almost 159,000 educational activities that were certified for AMA PRA Category 1 Credit.™ AMA PRA requirements mandate that all accredited CME providers maintain records for each physician who
participates in their CME activities and verify this participation if requested by the physician. The vast majority of CME providers do not report the actual number of credits awarded to individual physicians at the participant level. An exception to this is a new partnership between the ACCME and three American Board of Medical Specialties’ (ABMS) Member Boards. The American Board of Anesthesiology (ABA), American Board of Internal Medicine (ABIM), and American Board of Pediatrics (ABP) have established a relationship with the ACCME’s Program and Activity Reporting System (PARS). Through this partnership, CME providers upload physician-level data to the ACCME PARS system, which then can be transmitted directly to the specialty board. However, this transmission occurs only in those instances in which the credits are accepted by the specialty boards to meet their MOC requirements.

AMA PRA policy encourages physicians to report to the AMA any accredited CME provider that fails to provide documentation to a physician of his or her earned AMA PRA Category 1 Credits. Additionally, physicians can choose to apply for the AMA PRA, which many state licensing boards accept as demonstrating compliance with state CME requirements.

AOA

The AOA works with approximately 170 AOA-accredited sponsors that provide AOA Category 1 credit. It is the responsibility of the sponsor to report all CME credit earned by individual physicians to the AOA. For non-osteopathic-sponsored CME activities, it is the responsibility of the physician to provide documentation to the AOA. A certificate of attendance or letter of verification from the CME sponsor must be provided. The AOA tracks earned CME credits for individual physicians in a centralized online repository, the AOA “traCME” system. AOA members may view their CME profile/activity report online or contact the AOA for an electronic copy.

AAFP

AAFP members usually self-report CME credits to the AAFP. However, this is strictly voluntary. The AAFP does not require CME providers to provide certificates to CME participants; however, the AAFP encourages providers to offer certificates, since many members need them for state licensing and credentialing. CME providers are required to have a mechanism in place to document learner participation.

Comparison of Accrediting Bodies

Appendix A reviews the credit-related services currently offered by the three major CME credit systems.

CME TRACKING SERVICES

State Medical Societies

In preparation for the writing of this report, the Council canvassed state medical societies regarding their efforts to assist physicians with tracking CME to meet state licensure requirements. Of those who responded, four indicated that they offer related services beyond providing a transcript for their own CME activities:

- The Pennsylvania Medical Society (PMS) (www.pamedsoc.org/Tracker) allows physicians to enter their AMA PRA Category 1 Credits and AMA PRA Category 2 Credits into an
electronic tracking system called Tracker. This system shows physicians when they have met
the state’s licensing requirements and the PMS’s CME certificate requirements.

- The California Medical Association’s Institute for Medical Quality (IMQ) CME Certification
  Program (www.imq.org/continuingmedicaleducation/cmecertification.aspx) records and
  verifies AMA PRA Category 1 Credit™ for California-licensed physicians to meet the state
  medical board’s requirements for licensure. CME credits can be reported using an online form
  and CME transcripts can be viewed and printed from the IMQ online site. Physicians who
  participate in this program are not required to undergo an independent audit of their CME
  activities by the California Medical Board.

- The Florida Medical Association (FMA) tracks all CME it provides directly in each
  physician’s record in its membership database http://www.floridahealth.gov/licensing-and-
  regulation/ce.html). This allows the FMA to generate a transcript with all FMA directly-
  provided CME that a physician (member or non-member) has completed over a specific period
  of time. The FMA also electronically reports its CME attendance data to CE Broker, which is
  the official continuing education (CE) tracking system for the state of Florida. Any educational
  provider that is specifically approved by a medical licensing board in Florida is statutorily
  required to report its attendance data to CE Broker. Although organizations accredited through
  the ACCME system are not statutorily required to report attendance (as their approval is from
  an entity other than the medical licensing board), many ACCME and FMA-accredited CME
  providers in Florida choose to do this.

- The South Carolina Medical Association (SCMA) receives information from its accredited
  CME providers on a quarterly basis that is uploaded into its database, which also contains data
  from SCMA’s own CME activities. The SCMA provides, on a biennial basis, a report to the
  state Board of Medical Examiners of members who have submitted their CME for tracking and
  met the minimum standard for license renewal (https://www.scmedical.org/education).
  The SCMA also tracks all South Carolina physicians who participate in its online opioid courses
  and reports this biennially to the Board of Medical Examiners.

Specialty Societies

Specialty societies are more likely than state medical societies to offer CME tracking tools and
capabilities to their members, and this tracking is more likely to relate to MOC requirements.
Appendix B summarizes information obtained from 2013 and 2017 surveys of Council of Medical
Specialty Societies (CMSS) member organizations.

Personal Digital Strategies

A number of mobile apps and online services are available to track CME credit. A simple search of
the phrases “continuing medical education tracker” and “CME Tracker” in Apple’s App Store and
Google Play generated multiple hits, including JoyCE, CEAgent, CE Vault Healthcare Edition,
CME Tracker, eeds Mobile, My CE, and DocIt, among others. Online membership groups, such as
Doximity, and products, such as UpToDate, also offer some level of CME tracking. However, the
ability of these products to interface with accrediting bodies is unclear, and the product in many
cases seems to be more reflective of a transcript, rather than of a comprehensive tracking system.
Institutional Tracking Systems

Some hospital systems and institutions also offer a type of CME tracking through their credentialing offices or other similar bodies, although this credit tracking may apply only to credit granted for the health system’s own events/CME offerings, and there does not appear to be aggregated information regarding which systems offer these services at the national level. The Association of American Medical Colleges (AAMC) does not officially track which of its member institutions offer CME tracking as a physician employee benefit. However, the Alliance for Continuing Education in the Health Professions (ACEHP) notes that at least one of its major hospital system members, the Cleveland Clinic, offers its employed physicians a free database tool for tracking CME (although it is the responsibility of individual physicians to manage their CME).

DISCUSSION

Perceived Need for a National Repository

As noted in a previous report, the AMA recognizes that a centralized repository and online reporting system for CME credit would be very useful to today’s physicians. However, in addition to the duplicative nature of such a service, some CME providers might resist requirements to report information to an additional central repository as they already provide this service to their members. Furthermore, as noted, some specialty societies already have developed working relationships with their certifying boards as a member service. In addition, each CME provider is required to keep records of the credits it issues to meet the requirements of the AMA PRA Credit System, and this could create additional administrative work for their staff.

The 2013 survey of CME directors from CMSS member organizations found that the majority of specialty societies that manage a database of CME credits earned by their physician members would not prefer a centralized credit database in lieu of their services, as they considered their own CME tracking services to be a valuable member benefit. At that time, specialty societies also were concerned about the potential data integrity/ownership/security issues that could arise with the development of a centralized database.

A 2017 survey of CMSS member societies reinforced this group’s lack of support for the creation of centralized repository; respondents cited multiple reasons for their opinions. “Creating a centralized database would only create additional work for us to copy the records we have to keep into an outside system and answer member questions when the centralized system has errors or the information we provide doesn’t upload correctly,” wrote one respondent. Another noted, “We want to incentivize physicians to see our learning center as their digital home for medical education. Centralizing CME credits elsewhere would fragment that experience.” Others noted the difficulties inherent in creating and maintaining such a system: “This could potentially be a real benefit for physicians. However, it will only be beneficial if there is 100% participation by CME providers, and 100% adoption by the organizations who require CME or coordinate MOC and other elements with CME. The amount of coordination and resources it would take on the part of all organizations involved should not be underestimated.” Another responded, “We understand the AMA’s desire for greater centralization of the data. We request that a large organization like the AMA take into consideration the butterfly effect. One phrase mandating change may seem like a small improvement for the CME enterprise, but will most certainly have a significant impact on the budget for each CME provider.”
Barriers

Additional barriers to the implementation of a centralized tracking system include funding, staffing, and technical and security requirements. In order to create a central repository, all CME providers would need to agree upon technical and data security proposals to ensure interoperability and determine who would pay for database development and maintenance. On several previous occasions, the AMA has considered development of a central repository, but in-depth analysis indicated that such a repository would be impractical due to complexity and cost. A system that includes AAFP and AOA credit would be more complex still.

Opportunities

Suggestions have been made that a remedy could be achieved through the creation of a single web link, which, when followed, directs users to a page with additional links to all specialty society, state medical society, AAFP, AMA, and AOA CME pages (and their vendors that handle CME reporting services). This potentially could reduce the amount of time and frustration physicians currently experience when attempting to access multiple sites. However, this solution would place responsibility on these groups to ensure all links are accurate and up-to-date. Furthermore, simply creating a page of links to reporting sites does not ensure that all credits a physician reports to these sites are automatically shared with licensing bodies.

The AMA is currently developing its Education Center, which aims to improve health and health care and enhance professional competency and satisfaction through trusted, innovative educational resources. The Education Center will deliver education that is based on user needs and focuses on user experience. Today, the Education Center includes routine transcript functionality. In the near term, it will be developing and testing features that support improved and expanded CME tracking and reporting.

RELEVANT AMA POLICY

The AMA Code of Medical Ethics (Opinions on Professional Self-Regulation, E-9.2.6 “Continuing Medical Education”) and existing AMA policy support lifelong learning. Related policies include the following:

- The AMA Principles of Medical Ethics state, V.) A physician shall continue to study, apply, and advance scientific knowledge, maintain a commitment to medical education, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
- Policy D-300.999, “Registration of Accredited CME Sponsors,” states that our AMA will: (1) continue cooperative efforts to assure that accredited sponsors of continuing medical education adhere to AMA Physician’s Recognition Award (PRA) policy when designating AMA PRA credit; and (2) remind all accredited CME providers of their responsibility, as stated in the AMA PRA requirements, to provide documentation to participating physicians of the credit awarded at the request of the physician.
- Policy H-300.980, “Focused Continuing Education Programs for Enhanced Clinical Competence,” states that the AMA: (1) encourages state and, where appropriate, local medical societies to respond to the needs of physicians who have been identified as requiring focused continuing medical education; (2) encourages state and county medical societies to cooperate with organizations and agencies concerned with physician competence, such as state licensing boards, and to assist in providing opportunities for physicians to participate in focused continuing education programs; (3) supports the collection and dissemination of information on
focused continuing medical education programs that have been developed or are in the process of development; and (4) recommends that organizations with responsibilities for patient care and patient safety request physicians to engage in content-specific educational activities only when there is a reasonable expectation that the CME intervention will be appropriate for the physician and effective in improving patient care or increasing patient safety in the context of the physicians’ practice.

- Policy H-300.958, “Support for Continuing Medical Education,” states that the AMA:
  1. Supports the concept of lifelong learning by recognizing the importance of continuing medical education as an integral part of medical education, along with undergraduate and graduate medical education;
  2. Encourages physicians to maintain and advance their clinical competence and keep up with changes in health care delivery brought about by health system reform;
  3. Assists and supports the expansion and enhancement of funding resources for continuing medical education on a local, regional, and national basis through foundations, private industry, health care organizations and appropriate government agencies;
  4. Encourages U.S. medical schools to integrate continuing medical education into the continuum of undergraduate and graduate medical education;
  5. Supports and assists medical schools, teaching institutions, and other health-related organizations in developing and facilitating implementation of health policy that supports research in continuing medical education, relevant to the needs of practicing physicians; and
  6. Supports efforts to facilitate and speed development of computer-based interactive and distance learning technologies to support learning needs of practicing physicians regardless of their geographic location.

- Policy H-275.924, “Maintenance of Certification,” states in part that: (10) In relation to MOC Part II, our AMA continues to support and promote the AMA Physician’s Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

CONCLUSION AND AREAS FOR FURTHER STUDY

CME credit is currently tracked and monitored to a varying degree by a wide variety of organizations at the state, specialty society, and institutional level, but as a result, physicians lack a single tool to track all types of earned CME credit, including credit earned from multiple CME providers or CME earned from one provider that is applied for multiple purposes (such as state licensing renewal and MOC). Because the nature of tracking and monitoring CME credit can be so specialized, the creation and maintenance of a centralized repository—while helpful for physicians—may not be feasible at this time due to a myriad of factors. Despite these challenges, however, appropriate departments within the AMA should continue to monitor advancements in technology and changes in the CME environment that may inform future deliberations on this topic, and the AMA should continue to actively work with the ABMS, ACCME, the CME provider community including state medical and professional societies, and other CME stakeholders to address these and related issues.
APPENDIX A: CREDIT-RELATED SERVICES OFFERED BY THE THREE MAJOR CREDIT SYSTEMS

<table>
<thead>
<tr>
<th></th>
<th>Is tracking provided for participants of credit system activities?</th>
<th>Which types of activities are tracked for inclusion in the transcript/CME report?</th>
<th>Is there a fee for tracking?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Members</td>
<td>Non-members</td>
<td>Credit system’s own activities as a CME provider</td>
</tr>
<tr>
<td>AAFP¹</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>AMA²</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>AOA³</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

¹ The AAFP directly certifies CME activities offering AAFP credit; these activities are listed on the AAFP website. Activity providers can report activity completion, including credits earned by members. This is optional, and not all activity providers do this; however, if done, the credits are automatically entered into the members’ AAFP transcripts. Individual physician members can also report activity completion and credits earned, and the information is entered into their AAFP transcript. For activities for which the AAFP is the accredited CME provider, the credit is automatically included in the transcript. Non-members receive a letter of participation for each activity, but not a transcript.

² AMA transcripts include credit for CME activities for which the AMA is the accredited CME provider. However, AMA PRA Category 1 Credits™ awarded by the AMA for credit conversions through international agreements, international conference recognition program conferences, and direct credit categories are not included in the transcript at this time. Anyone can self-report AMA PRA Category 1 Credits™ activities from other accredited CME providers and activities for other types of credit.

³ The AOA tracks AOA credits for DO members and non-members, but only DO members are provided access to their CME report, which reflects the credits. AOA credits are reported by the AOA sponsors and posted to the CME activity report. DO members also self-report AMA PRA Category 1 Credits™ and AAFP credits, and these are included on the CME activity report.
APPENDIX B: SURVEY OF CMSS MEMBER SOCIETIES REGARDING CME TRACKING

<table>
<thead>
<tr>
<th>Does your society maintain a database of CME credits earned annually for any of the following? Please check all that apply.</th>
<th>2013 (N = 17)</th>
<th>2017 (N = 14)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member physicians, for CME offered by your society</td>
<td>15 (93.8)</td>
<td>14 (100.0)</td>
</tr>
<tr>
<td>Non-member physicians in your specialty, for CME offered by your society</td>
<td>11 (68.8)</td>
<td>12 (92.3)</td>
</tr>
<tr>
<td>Member physicians, for CME offered by any CME provider</td>
<td>6 (37.5)</td>
<td>6 (50.0)</td>
</tr>
<tr>
<td>Non-member physicians in your specialty, for CME offered by any CME provider</td>
<td>3 (18.8)</td>
<td>3 (25.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If your membership organization offers this service, is there an additional fee associated with tracking the CME?</th>
<th>2013</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>0 (0.0)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>No</td>
<td>16 (100.0)</td>
<td>12 (100.0)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Would you prefer a centralized database of CME credits earned by all physicians in lieu of managing such a database through your society?</th>
<th>2013</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2 (12.5)</td>
<td>0 (0.0)</td>
</tr>
<tr>
<td>No</td>
<td>9 (56.3)</td>
<td>6 (60.0)</td>
</tr>
<tr>
<td>Unsure</td>
<td>5 (31.2)</td>
<td>4 (40.0)</td>
</tr>
</tbody>
</table>

*Percentages calculated based on the number of respondents answering the individual question.
REFERENCES


8 Personal communication, Stacia Gueriguian, Director of Meetings, Association of American Medical Colleges. July 12, 2017.

9 Personal communication, Laurie Kendall-Ellis, Executive Director and CEO, Alliance for Continuing Education in the Health Professions. July 12, 2017.
REPORT OF THE SPEAKERS

Speakers’ Report 1-I-17

Subject: Recommendations for Policy Reconciliation

Presented by: Susan R. Bailey, MD, Speaker
              Bruce A. Scott, MD, Vice Speaker

Policy G-600.111, “Consolidation and Reconciliation of AMA Policy,” states in relevant part that
the Speakers should “present one or more reconciliation reports for action by the House of
Delegates relating to newly passed policies from recent meetings that caused one or more existing
policies to be redundant and/or obsolete.”

Your Speakers present this report, the second of 2017, to deal with policies that were affected by
actions taken at this past June’s Annual Meeting.

Suggestions on other policy statements that are thought to be outdated or needing revision for any
other reason should be sent to hod@ama-assn.org. That address may also be used to contact your
Speakers on any House-related matter.

RECOMMENDED RECONCILIATIONS

References to completed directives to be deleted from policy statements

The following changes will delete references to reports that have been completed but otherwise do
not affect existing policy.

1. Policy D-405.988, “The Preservation of the Private Practice of Medicine,” includes a reference
to a report that was considered by the House at the 2015 Annual Meeting as Board of Trustees
Report 16. That reference will be stricken, but the remainder of the policy unchanged.

Policy D-405.988, “The Preservation of the Private Practice of Medicine”
Our AMA: (1) supports preserving the value of the private practice of medicine and its benefit
to patients; (2) will utilize its resources to protect and support the continued existence of solo
and small group medical practice, and to protect and support the ability of these practices to
provide quality care; (3) will advocate in Congress to ensure adequate payment for services
rendered by private practicing physicians; (4) will work through the appropriate channels to
preserve choices and opportunities, including the private practice of medicine, for new
physicians whose choices and opportunities may be limited due to their significant medical
education debt; (5) will work through the appropriate channels to ensure that medical students
and residents during their training are educated in all of medicine's career choices, including
the private practice of medicine; (6) will create, maintain, and make accessible to medical
students, residents and fellows, and physicians, resources to enhance satisfaction and practice
sustainability for physicians in private practice, with a progress report at the 2015 Annual
Meeting; and (7) will create and maintain a reference document establishing principles for
entering into and sustaining a private practice, and encourage medical schools and residency

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programs to present physicians in training with information regarding private practice as a viable option.

2. Policy G-600.035, “The Demographics of the House of Delegates” includes a directive that has been accomplished. The Council on Long Range Planning and Development provided the requested information in Report 2-A-17. Having been completed, the directive will be dropped.

Policy G-600.035, “The Demographics of the House of Delegates”
1. A report on the demographics of our AMA House of Delegates will be issued annually and include information regarding age, gender, race/ethnicity, education, life stage, present employment, and self-designated specialty. 2. As one means of encouraging greater awareness and responsiveness to diversity, our AMA will prepare and distribute a state-by-state demographic analysis of the House of Delegates, with comparisons to the physician population and to our AMA physician membership every other year. 3. Future reports on the demographic characteristics of the House of Delegates will identify and include information on successful initiatives and best practices to promote diversity, particularly by age, of state and specialty society delegations. 4. Our AMA will convene a group of stakeholders at a forum in conjunction with the 2016 Annual Meeting to identify viable solutions with which to promote diversity, particularly by age, of state and specialty society delegations, with a summary of the findings to be included in the next CLRPD report on the demographic characteristics of the House of Delegates.

3. H-110.987, “Pharmaceutical Cost,” calls for a progress report on a “drug pricing advocacy campaign at the 2016 Interim Meeting.” That report was delivered in Board of Trustees Report 10, AMA Initiatives on Pharmaceutical Costs. Hence the specific call for the report will be removed from policy.

H-110.987, “Pharmaceutical Cost”
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives. 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition. 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry. 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system. 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies. 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation. 7. Our AMA supports legislation to shorten the exclusivity period for biologics. 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens. 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting.
Policies to be rescinded in full

Five policies should be rescinded in full because they have been superseded by newer policies and, where necessary, bylaws amendments. Three policies deal with specialty society representation, a process that has been completely revised over the last year. Two other policy statements are directives dealing with the Council on Ethical and Judicial Affairs; both have been accomplished and should be rescinded.

4. Two policies deal with the now abandoned balloting system used for apportioning delegates to specialty societies. In light of amendments to the bylaws and Policy G-600.027 at the 2017 Annual Meeting, these older policies should be rescinded. The first is Policy G-600.023, “Designation of Specialty Societies for Representation in the House of Delegates,” which was adopted at the 2013 Interim Meeting. Although the final paragraph of the policy has some merit, your Speakers believe that it is incumbent on them to monitor the delegate allocation process and no explicit requirement is needed. Moreover, in the event of a perceived problem, any delegate may propose a resolution to address the matter. As such, the policy as a whole is no longer viable and will be rescinded.

Policy G-600.023, “Designation of Specialty Societies for Representation in the House of Delegates”

1. Specialty society delegate allocation in the House of Delegates shall be determined in the same manner as state medical society delegate allocation based on membership numbers allowing one delegate per 1,000 AMA members or fraction thereof. 2. Specialty society membership data shall be submitted annually by all societies with more than one delegate or societies seeking to obtain an additional delegate or delegates as part of a two-year pilot program with a report back at the 2016 Annual Meeting of our AMA House of Delegates. 3. The current specialty delegation allocation system (ballot and formula) will be continued until the pilot program is completed and the 2016 Annual Meeting report is acted upon by the House of Delegates. 4. This system shall be tested with all specialty societies with more than one delegate seated in the House of Delegates. 5. Organizations that would lose or gain one or more delegates through this pilot delegate allocation system shall assist our AMA with documenting the impact. However, no actual changes to delegation allocation other than those which occur through the five-year review and balloting system will be implemented until the data are collected and presented for acceptance to our AMA House of Delegates at the 2016 Annual Meeting. 6. In the future, any system of delegate allocation will continue to be monitored and evaluated for improvements.

5. Likewise, Policy G-600.021, “Specialty Society Representation in our AMA House,” which dates from 1996 and was altered in 2012, will be rescinded.

Policy G-600.021, “Specialty Society Representation in our AMA House”

The number of AMA delegate positions allocated to the specialty societies in our AMA/Federation House will be determined in the following manner: (1) The number of delegates and alternate delegates allocated to a specialty society will be on the basis of one delegate and one alternate delegate for each 1000 AMA members, or portion of 1000 AMA members, who select that a particular specialty society on the annual ballot and return the ballot to our AMA; and (2) Each specialty society that meets the eligibility criteria and is represented in our AMA/Federation House will be assured of at least one delegate and alternate delegate position regardless of the number of AMA members who select the society on the ballot and return the ballot to the AMA. (3) Our AMA will: (a) continue to include the ballot postcard in the Member Welcome Kit; (b) continue to promote the online ballot application to
increase specialty society designations; (c) work with all willing specialty societies to solicit additional specialty society designations, using both printed ballots and electronic communications vehicles; and (d) continue to send email ballot solicitations to members who have not yet cast a ballot. (4) The current ballot system will remain in place while the Speakers, working with the Specialty and Service Society, examine other options for ensuring that each member of the American Medical Association is adequately represented by both a state medical association and national medical specialty society.

6. Policy G-600.135, “Specialty Society Delegate Representation in the House of Delegates,” will be rescinded as it has been superseded by the new procedure to apportion specialty society delegates that will be implemented in 2018.


1. Our AMA will continue efforts to expand awareness and use of the designation mechanism for specialty society representation, working wherever possible with relevant members of the Federation. 2. The system of apportioning delegates to specialty societies be enhanced by a systematic allocation of delegates to specialty societies by extrapolating from the current process in which members designate a specialty society for representation. The recommended model will: (a) establish annual targets for the overall proportion of AMA members from whom designations should have been received; (b) adjust actual designations by increasing them proportionately to achieve the overall target level of designations; (c) limit the number of delegates a society can acquire to the number that would be obtained if all the society’s AMA members designated it for representation; (d) be initiated with delegate allocations for 2008, following the expiration of the freeze, which ends December 31, 2007; and (e) be implemented over five years because this will result in the least disruption to the House of Delegates and allow the process to unfold naturally. 3. The Board of Trustees will prepare annual reports to the House describing efforts undertaken to solicit designations from members, characterizing progress in collecting designations, and recommending changes in strategies that might be required to implement existing policy on representation of specialty societies. In addition, the Board should, in these or other reports: (a) develop a system for use among direct members to solicit their designations of specialty societies for representation, with an eye on how that system might be expanded or adapted for use among other members; and (b) engage in discussions with specialty societies that will lead to enhanced data sharing so that delegate allocations for both state and specialty societies can be handled in parallel fashion. 4. Our AMA will include in the specialty designation system an option to permit those members who wish to opt out of representation by a specialty society to do so when any automatic allocation system is used to provide representation for specialty societies that are represented in the House of Delegates. 5. If any specialty society loses delegates as a result of the apportionment process, the specialty society shall have a one-year grace period commencing January 1, 2008. At the expiration of this one-year grace period, a phase-in period shall be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented. 6. AMA Bylaw 2.11111 grants state societies a one-year grace period following the freeze expiring December 31, 2007 (per Bylaw 2.121). At the end of the grace period, a phase-in period will be implemented such that the number of delegate seats lost will be limited to one seat per year for the succeeding three years. In the fourth year, any remaining reduction of seats will be implemented.

7. The multi-year effort by the Council on Ethical and Judicial Affairs to modernize the Code of Medical Ethics culminated with the adoption of CEJA Report 2-A-16. At that same meeting, and partly because of the lengthy and somewhat tortuous effort to achieve consensus on the
Code, the House also adopted Policy D-600.957 calling for an evaluation of the deliberative processes surrounding CEJA reports. The initial response to that policy came in CEJA Report 3-I-16, which was referred because important underlying issues of the relationship between the Council and the HOD required further study. At the 2017 Annual Meeting, the Board of Trustees submitted Report 19, providing the requested evaluation and establishing Policy G-600.009, “CEJA and House of Delegates Collaboration.” Given the Board’s report, the following policy has been accomplished and will be rescinded.

D-600.957, “CEJA and House of Delegates Deliberation”
1. Our AMA will evaluate how the collaborative process between the House of Delegates and the Council on Ethical and Judicial Affairs can best be improved to allow HOD input to CEJA deliberation while still preserving CEJA autonomy and report back at the 2016 Interim Meeting. 2. Our AMA will evaluate how a periodic review of Code of Medical Ethics guidelines and reports can best be implemented, and report back.

Policy D-478.969, “Social Media Trends and the Medical Profession,” asked that CEJA examine how physicians may ethically use social media for educational and advocacy purposes. CEJA submitted Report 2 at this past June’s meeting, which included a section dealing specifically with uses of social media for education or advocacy. The policy will be rescinded as having been completed.

D-478.969, “Social Media Trends and the Medical Profession”
Our AMA will ask the Council on Ethical and Judicial Affairs to reconsider AMA Ethical Opinion E-9.124, Professionalism in the Use of Social Media.

Policies to be modified

The most recent policy dealing with the apportionment of specialty society delegates requires relatively minor modifications to bring it up to date.

G-600.027, “Designation of Specialty Societies for Representation in the House of Delegates,” was modified at 2017 Annual Meeting to clarify the formula that will be used to apportion delegates to specialty societies in the House of Delegates. The policy will be modified to delete a call to study bylaws changes necessitated by the policy change and the date of the initiation of the policy as those elements are no longer relevant.

1. The current specialty society delegation allocation system (using a formula that incorporates the ballot) will be discontinued; and specialty society delegate allocation in the House of Delegates will be determined so that the total number of national specialty society delegates shall be equal to the total number of delegates apportioned to constituent societies under section 2.1.1 (and subsections thereof) of AMA bylaws, and will be distributed based on the latest available membership data for each society, which is generally from the society's most recent five year review, but may be determined annually at the society's request.

2. Specialty society delegate allocation will be determined annually, based on the latest available membership data, using a two-step process: (a) First, the number of delegates per specialty society will be calculated as one delegate per 1,000 AMA members in that society, or fraction thereof. (i) At the time of this calculation, any specialty society that has applied for representation in the HOD, and has met SSS criteria for representation, will be apportioned delegates in anticipation of its formal acceptance to the HOD at the
subsequent Annual Meeting. Should the society not be accepted, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

(b) Second, the total number of specialty society delegates will be adjusted up or down to equal the number of delegates allocated to constituent societies.

(i) Should the calculated total number of specialty society delegates be fewer than the total number of delegates allocated to constituent societies, additional delegates will be apportioned, one each, to those societies that are numerically closest to qualifying for an additional delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

(ii) Should the calculated total number of specialty society delegates be greater than the number of delegates allocated to constituent societies, then the excess delegates will be removed, one each, from those societies numerically closest to losing a delegate, until the total number of national specialty society delegates equals the number of constituent society delegates.

(iii) In the case of a tie, the previous year’s data will be used as a tie breaker. In the case of an additional delegate being necessary, the society that was closest to gaining a delegate in the previous year will be awarded the delegate. In the case of a delegate reduction being necessary, the society that was next closest to losing a delegate in the previous year will lose a delegate.

3. The Council on Constitution and Bylaws will investigate the need to change any policy or bylaws needed to implement a new system to apportion national medical specialty society delegates.

4. This new specialty society delegate apportionment process will be implemented at the first Annual Meeting of the House of Delegates following the necessary bylaws revisions.

5. Should a specialty society lose representation during a meeting of the HOD, the delegate seat(s) apportioned to that society will remain vacant until the apportionment of delegates occurs the following year.

The policy below requires a slight change to use the preferred language consistently. The change is presented here in the interest of transparency. The original sponsor favors the change.

10. In June the House adopted policy supporting the use of “person-first” language in addressing the needs of patients affected by obesity, which is catalogued as Policy H-440.821, “Person-First Language for Obesity.” The language in the third paragraph is slightly inconsistent as adopted and will be changed from “patient-first” to “person-first.”

Our AMA: (1) encourages the use of person-first language (patients with obesity, patients affected by obesity) in all discussions, resolutions and reports regarding obesity; (2) encourages the use of preferred terms in discussions, resolutions and reports regarding patients affected by obesity including weight and unhealthy weight, and discourage the use of stigmatizing terms including obese, morbidly obese, and fat; and (3) will educate health care providers on the importance of patient person-first language for treating patients with obesity; equipping their health care facilities with proper sized furniture, medical equipment and gowns for patients with obesity; and having patients weighed respectfully.

The changes outlined above do not reset the sunset clock and will be implemented when this report is filed.

Fiscal note: $250 to edit policy database.
Not for consideration

Resolutions not for consideration

212   Physician Identification
602   Creation of LGBTQ Health Specialty Section Council
603   A Guide for Best Health Practices for Seniors Living in Retirement Communities
951   Financial Protections for Doctors in Training
Whereas, Health care facilities are inundated with personnel wearing white coats, scrubs or stethoscopes; and
Whereas, It can be difficult for our patients to distinguish physicians and nurses from other health facility personnel; and
Whereas, Because professional abbreviations are increasingly complex and confusing, they should not be used on health professional ID tags; therefore, be it
RESOLVED, That our American Medical Association adopt nationally standardized whole word labels to be used on health professional and health worker ID tags. (New HOD Policy)

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

Received: 09/26/17
Whereas, The AMA House of Delegates (HOD) allows for the creation of Specialty Section Councils composed of member organizations with common medical interests or specialty training (B-9.1); and

Whereas, The AMA HOD currently recognizes thirty-one (31) Specialty Section Councils within the House of Delegates (B-14.0.1); and

Whereas, LGBTQ Health has become a fully acknowledged subspecialty of medical practice, spanning a range of medical specialties including, but not limited to, internal medicine, pediatrics, geriatrics, obstetrics and gynecology, endocrinology, plastic surgery; and

Whereas, The study and practice of LGBTQ Health as a recognized subspecialty is vital due to the presence of well-established medical disparities that affect this population; and

Whereas, The AMA Foundation, recognizing the importance of LGBTQ specific medical training, has chosen to utilize the LGBT Honor Fund to establish the creation of subspecialty fellowship training programs in LGBTQ Health; therefore be it

RESOLVED, That our American Medical Association House of Delegates establish a Specialty Section Council on LGBTQ Health. (Directive to Take Action)

Fiscal Note: No significant fiscal impact.

Received: 09/28/17

RELEVANT AMA POLICY

B-9.1 Purpose.
9.1.1 Specialty Section Councils shall be established by the House of Delegates. Specialty Section Councils shall provide for deliberation and study of scientific educational and other appropriate interests and concerns of the specialty disciplines and the specialty societies representing these disciplines within the AMA.

9.1.2 The Section Council shall, on request, submit to the Board of Trustees nominations for AMA representatives to serve on approved Specialty Certifying Boards.
B-9.2 Composition.
9.2.1 National medical specialty societies represented in the House of Delegates may appoint representatives to the Specialty Section Councils for the medical specialty in which the specialty society participates. Such representatives must be members of the AMA.
9.2.2 Upon recommendation of the Specialty Section Council and approval of the Board of Trustees, national medical specialty societies that are not represented in the House of Delegates may appoint representatives to the Specialty Section Council for the medical specialty in which the specialty society participates. Such representatives must be members of the AMA.

B-9.3 Specialty Society Delegate.
The AMA delegate(s) and alternate delegate(s) from each national medical specialty society represented in the House of Delegates shall also serve in the Specialty Section Council of their respective specialty.

B-9.4 Chair and Vice Chair.
Each Specialty Section Council shall elect a Chair and Vice Chair from within its membership.

B-14.0.1 Glossary of Terms.
Section Council - Specialty Section Councils have been recognized by the House of Delegates for the following specialties: Allergy; Anesthesiology; Cardiovascular Disease; Clinical Pharmacology and Therapeutics; Dermatology; Digestive Diseases; Disease of the Chest; Emergency Medicine; Endocrinology; Family and General Practice; Federal and Military Medicine; General Surgery; Genetics; Internal Medicine; Neurological Surgery; Neurology; Nuclear Medicine; Obstetrics and Gynecology; Ophthalmology; Orthopedic Surgery; Otolaryngology-Head and Neck Surgery; Pain and Palliative Medicine; Pathology; Pediatrics; Physical Medicine and Rehabilitation; Plastic, Reconstructive and Maxillofacial Surgery; Preventive Medicine; Psychiatry; Radiology; and Urology.
Whereas, The AMA-Senior Physicians Section mission is to engage physicians age 65 and above, both active and retired, to promote policies, products and services relevant to senior physicians; and

Whereas, The number of seniors in the United States is growing exponentially, with currently 46 million people age 65 or older with the number expected to grow to 73 million in the next 15 years¹; and

Whereas, The “Baby Boomer” generation (generally accepted as birth dates between 1946 to 1964) is 74.9 million²; and

Whereas, Large numbers of these groups live independently in retirement communities not subject to any state or federal regulations as are required for assisted living, extended care and nursing homes; and

Whereas, AARP has published its second edition of “Where We Live: Communities for All Ages” with a focus on communities in the forefront in addressing the needs of an aging population³; and

Whereas, Many senior physicians live in such communities and could be a resource for their communities in matters of health and wellness, enhancing the health of the community’s residents, were there a template of suggestions to guide their efforts; and

Whereas, Although there are guidelines for immunizations from the CDC and publications touting the validity of exercise programs for the elderly, they are not cohesive and in “one place;” and

Whereas, There are no guidelines for independent living communities (on activities) that could prevent communicable diseases or even save lives (e.g. alcohol/soap hand dispensers in communal areas, maintenance suggestions for decorative fountains and cooling towers, placement of AEDs [AEDs — automated external defibrillators — can be found in almost every school building and airport but how many are in senior living facilities?]); and

Whereas, Senior citizens have special needs that may include safety features (e.g. wider doorways, absence of area rugs, leveling of doorsills), accommodations for disabilities, improved bathroom accessibility and enhanced lighting; therefore be it

RESOLVED, That our American Medical Association, including other interested parties such as the public health community, geriatric specialties, and AARP, study the development of a document that could guide best health practices for the senior independent living community.

(Directive to Take Action)

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

Received: 09/29/17
WHEREAS, The AMA has guidelines that expect all institutions to provide retirement benefits; and

WHEREAS, With resident and fellowship matching, physicians do not have choice in the benefit package causing differences in retirement outcomes; and

WHEREAS, Physicians should be saving 15% of their funding towards retirements, but studies have shown that physicians have not been saving enough due to multiple reason including significant student debt, delayed start in professional life, and decreased financial literacy; and

WHEREAS, Evidence has shown that employers who match retirement savings, result in employees saving significantly more annual for retirement; therefore be it

RESOLVED, That our American Medical Association support retirement plans for all residents and fellows, which includes retirement plan matching in order to further secure the financial stability of physicians and increase financial literacy during training (New HOD Policy); and be it further

RESOLVED, That our AMA support that all programs provide financial advising to resident and fellows. (New HOD Policy)

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

Received: 09/06/17