Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Education Report 1 – Promoting and Reaffirming Domestic Medical School Clerkship Education
3. Council on Science and Public Health Report 3 – Neuropathic Pain as a Disease Update
5. Resolution 910 – Improving Treatment and Diagnosis of Maternal Depression through Screening and State-Based Care Coordination
6. Resolution 911 – State Maternal Mortality Review Committees
7. Resolution 913 – Increased Death Rate and Decreased Life Expectancy in the United States

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

   In lieu of Resolution 915 – Easing Barriers to Medical Research on Marijuana Derivatives
10. Resolution 901 – Harmful Effects of Screen Time in Children
11. Resolution 902 – Expanding Expedited Partner Therapy to Treat Trichomoniasis
12. Resolution 903 – Improving Screening and Treatment Guidelines for Domestic Violence Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals
13. Resolution 904 – Educating Physicians About the Importance of Cervical Cancer Screening for Female-to-Male Transgender Patients
14. Resolution 905 – Addressing Social Media Usage and its Negative Impacts on Mental Health
15. Resolution 906 – Opioid Abuse in Breastfeeding Mothers
16. Resolution 907 – Addressing Healthcare Needs of Foster Children
17. Resolution 908 – Updating Energy Policy and Extraction Regulations to Promote Public Health and Sustainability
18. Resolution 909 – Expanding Naloxone Programs
19. Resolution 912 – Corrective Statements Ordered to be Published by Tobacco Companies for the Violation of the Racketeer Influenced and Corrupt Organizations Act
20. Resolution 914 – Support of Training, Ongoing Education, and Consultation in Order to Reduce the Health Impact of Pediatric Environmental Chemical Exposures
21. Resolution 916 – Hospital Disaster Plans And Medical Staffs
22. Resolution 952 – Implicit Bias, Diversity and Inclusion in Medical Education and Residency Training
23. Resolution 953 – Fees for Taking Maintenance of Certification Examination
24. Resolution 954 – Developing Physician Led Public Health/Population Health Capacity in Rural Communities
25. Resolution 955 – Minimization of Bias in the Electronic Residency Application Service Residency Application
26. Resolution 957 – Standardization of Family Planning Training Opportunities in OB-GYN Residencies
27. Resolution 958 – Sex and Gender Based Medicine in Clinical Medical Education
28. Resolution 959 – Lifestyle Medicine Education in Medical School Training and Practice
29. Resolution 960 – Medical Student Involvement and Validation of the Standardized Video Interview Implementation

RECOMMENDED FOR NOT ADOPTION

30. Resolution 956 – House Physicians Category
(1) COUNCIL ON MEDICAL EDUCATION REPORT 1 –
PROMOTING AND REAFFIRMING DOMESTIC MEDICAL
SCHOOL CLERKSHIP EDUCATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that the recommendations in Council on Medical Education
Report 1 be adopted and the remainder of the report be
filed.

Council on Medical Education Report 1, in response to Resolution 308-I-16, considers
concerns that have been raised about the availability of clinical clerkship training sites
due to continuing increases in the enrollment of U.S. allopathic and osteopathic medical
schools and in the absolute numbers of U.S. medical schools—as well as the growing
number of foreign medical schools that seek to place their students in clerkships in U.S.
institutions. The Council on Medical Education recommends that the following
recommendations be adopted in lieu of Resolution 308-I-16 and the remainder of the
report be filed:

1. That our American Medical Association (AMA):
   1) Work with the Association of American Medical Colleges, American
      Association of Colleges of Osteopathic Medicine, and other interested
      stakeholders to encourage local and state governments and the federal
government, as well as private sector philanthropies, to provide additional
funding to support: a) infrastructure and faculty development and capacity for
medical school expansion; and b) delivery of clinical clerkships and other
educational experiences. (Directive to Take Action)
   2) Encourage clinical clerkship sites for medical education (to include medical
      schools and teaching hospitals) to collaborate with local, state, and regional
partners to create additional clinical education sites and resources for
students. (Directive to Take Action)
   3) Advocate for federal and state legislation/regulations to:
      a. Oppose any extraordinary compensation granted to clinical clerkship
sites that would displace or otherwise limit the education/training
opportunities for medical students in clinical rotations enrolled in
medical school programs accredited by the Liaison Committee on
Medical Education (LCME) or Commission on Osteopathic College
Accreditation (COCA);
      b. Ensure that priority for clinical clerkship slots be given first to students
of LCME- or COCA-accredited medical school programs; and
      c. Require that any institution that accepts students for clinical
placements ensure that all such students are trained in programs that
meet requirements for educational quality, curriculum, clinical
experiences and attending supervision that are equivalent to those of
programs accredited by the LCME and COCA. (Directive to Take
Action)
   4) Encourage relevant stakeholders to study whether the “public service
community benefit” commitment and corporate purposes of not for profit, tax
exempt hospitals impose any legal and/or ethical obligations for granting
priority access for teaching purposes to medical students from medical
schools in their service area communities and, if so, advocate for the
development of appropriate regulations at the state level. (Directive to Take
Action)

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

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

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

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

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

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

Your Reference Committee heard testimony in strong support of the work of the Council
on Medical Education on this topic. The AMA’s long and storied history of ensuring the
highest quality of medical education is underscored by this report, which emphasizes the
need for the continued availability of clinical clerkship training sites in the face of
increased enrollment in U.S. allopathic and osteopathic medical schools, in the absolute
number of U.S. medical schools, and the growing number of foreign medical schools that
seek to place their students at U.S. institutions for their clinical clerkships. The overall
quality of medical education in the United States could be compromised by having too
many learners for the currently available capacity of the clerkship environment. Your
Reference Committee recommends adoption as written.
RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 2 be adopted and the remainder of the report be filed.

Council on Science and Public Health Report 2 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. The Council on Science and Public Health recommends that the following statements be adopted and the remainder of the report be 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)

Testimony was unanimously supportive of CSAPH 2, which evaluates both the factors influencing the decision to designate oneself as an organ donor and the educational interventions that have successfully targeted segments of the population most in need to improve organ donation rates. A continuing need to address this issue and reduce existing disparities was noted. Your Reference Committee urges adoption of the report’s recommendations.
(3) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
3 – NEUROPATHIC PAIN AS A DISEASE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 3 be adopted and the remainder of the report be filed.

Council on Science and Public Health Report 3 is in response to Resolution 912-I-16 and considers whether neuropathic pain should be recognized as a distinct disease state. The report discusses the complexities surrounding the issue and concludes that 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. 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 the 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)

The Council was thanked for developing this report, and general support was offered for their recommendation to have this issue further explored by the Federation-based Pain Care Task Force, which is in the process of being formed. The expertise that such a group will bring is important in evaluating this complex issue. Your Reference Committee concurs that the approach recommended is appropriate.

(4) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
4 – NATIONAL DRUG SHORTAGES: UPDATE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 4 be adopted and the remainder of the report be filed.

Council on Science and Public Health Report 4 is in response to policy H-100.956, which directs the Council to 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 in the U.S. This report provides an update on continuing trends in national drugs shortages and ongoing efforts to further evaluate and address this critical public health issue. The Council has issued seven previous reports on drug shortages and this report updates information on drug shortages since the 2016 report was developed. The Council on Science and Public Health recommends that Policy H-100.956 be amended by addition to read as follows and the remainder of the report be filed:

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. OurAMA 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)

The Council was thanked for their continuing attention to this critical issue, and strong support was expressed for the report and its recommendation. Testimony noted the damage that had occurred to multiple pharmaceutical manufacturing sites in Puerto Rico and how that could potentially worsen an already fragile supply of critical medications. The Council acknowledged that several new concerns have been identified that need to
be further examined and pledged to supply an updated report at A-18. Some concern was expressed about physicians being able to get current information about drugs that are in short supply; specific resources and mobile apps are available to help with that process. A request also was made to further examine the role of group purchasing organizations in drug shortages. The Council recommends adopting the current report to address issues that may impact mergers and acquisitions in the pharmaceutical industry, and promises to return an updated report to the House in June. Your Reference Committee concurs.

(5) RESOLUTION 910 – IMPROVING TREATMENT AND DIAGNOSIS OF MATERNAL DEPRESSION THROUGH SCREENING AND STATE-BASED CARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 910 be adopted.

Resolution 910 asks that our American Medical Association 1.) 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; 2.) encourage the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and 3.) 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.

Testimony noted the large public health burden attributable to prenatal and postnatal depression and the availability of resources from the National Institutes of Health for physician offices and clinics to raise awareness of this issue. Virtually unanimous testimony was offered in support of this resolution. Some debate centered on the wisdom of the third resolve, and whether it represents an unfunded mandate. A public law exists around establishing a screening and treatment program for maternal depression that would establish state-based grant programs for improving screening and treatment for pregnant and postpartum women experiencing maternal depression, but it is unfunded. Existing AMA policy already supports (1) improvements in mental health services for women during pregnancy and postpartum, (2) advocacy for insurance coverage of mental health services up to one year postpartum, and (3) organizations working to improve education and awareness of the risks of mental illness during gestation and postpartum. In the absence of further information, your Reference Committee recommends adopting the resolution.
(6) RESOLUTION 911 – STATE MATERNAL MORTALITY REVIEW COMMITTEES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 911 be adopted.

Resolution 911 asks that our AMA 1.) support the important work of maternal mortality review committees. 2.) support work with state and specialty medical societies to advocate for state and federal legislation establishing Maternal Mortality Review Committees; and 3.) support work with state and specialty medical societies to secure funding from state and federal governments that fully supports the start-up and ongoing work of state Maternal Mortality Review Committees.

Your Reference Committee heard testimony unanimously supportive of Resolution 911. Among developed countries, the United States has the highest maternal mortality rate. Significant disparities exist in maternal mortality rates among different racial groups. There is broad support in the maternal and child health community for the investigation of maternal deaths by a multi-disciplinary Maternal Mortality Review committee. Therefore, your Reference Committee recommends that Resolution 911 be adopted.

(7) RESOLUTION 913 – INCREASED DEATH RATE AND DECREASED LIFE EXPECTANCY IN THE UNITED STATES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 913 be adopted.

Resolution 913 asks that our American Medical Association 1.) raise awareness of the recent reversals in the improvement of overall death rates and life expectancy with the message that these new problems in the United States are different from all other developed countries and that these trends need to be reversed promptly; 2.) call on the legislative and executive branches of the Federal Government to fund and carry out investigations into the causes of these very unusual decreases in life expectancy and increases in death rates in order to design multi-disciplinary interventions to reverse these troubling changes; and 3.) encourage state and local medical societies to raise awareness of the new problems of decreasing life expectancy and increasing population death rates as indicators of major public health problems and advocate for local investigation of the causes and remedies for these disturbing problems.

Your Reference Committee heard a significant amount of testimony regarding this resolution. Many agreed with the sentiment of the resolution and noted that no current AMA policy exists on this topic. Many also supported further investigations into the causes of increased death rates and specifically noted increases in opioid mortality and suicide, and health equity variations by Zip code. Therefore, your Reference Committee recommends that Resolution 913 be adopted.
(8) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
1 – UNIVERSAL COLOR SCHEME FOR RESPIRATORY INHALERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 1 be amended by addition to read as follows:

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, and distinctive packaging features for rescue inhalers. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 1 be adopted as amended and the remainder of the report be filed.

Council on Science and Public Health Report 1, in response to Resolution 906-I-16, notes the limited evidence supporting color coding systems to reduce medication errors in outpatients. The disadvantages of using color coding systems are cited and experts, including the FDA, either oppose color coding or recommend caution in its application. 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. The Council on Science and Public Health recommends that the following be adopted in lieu of Resolution 906-I-16, “Universal Color Scheme for Respiratory Inhalers,” and the remainder of the report be filed:

Respiratory Inhaler Medications

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)

The Council was thanked for their work on this important topic. Considerable testimony was supportive of the Council’s report and the recommendation that was offered. Testimony was also offered supporting the color coding of rescue inhalers. Your Reference Committee understands that the Food and Drug Administration does not support color coding for a host of reasons, including colorblind patients, and that there is limited evidence to support the color coding of pharmaceutical products, but notes that other distinctive packaging features could be utilized to distinguish rescue inhalers from other inhalers and supports this research. Additionally, testimony was provided regarding the unintended consequences including the potential increased cost that could
be passed on to consumers if pharmaceutical manufacturers were required to change product color. Therefore, your Reference Committee recommends that the recommendation in Council on Science and Public Health Report 1 be adopted as amended.

(9) COUNCIL ON SCIENCE AND PUBLIC HEALTH REPORT
5 – CLINICAL IMPLICATIONS AND POLICY
CONSIDERATIONS OF CANNABIS

RESOLUTION 915 – EASING BARRIERS TO MEDICAL RESEARCH ON MARIJUANA DERIVATIVES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that recommendation 1 in Council on Science and Public Health Report 5 be amended by addition and deletion to read as follows:


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

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

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 3 in Council on Science and Public Health Report 5 be amended by addition and deletion to read as follows:

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

H-95.952, “Cannabis and Cannabinoid Research for Medicinal Use”

(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana’s status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of
Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. (5) Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. (Modify Current HOD Policy)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Science and Public Health Report 5 be adopted as amended in lieu of Resolution 915 and the remainder of the report be filed.

Council on Science and Public Health Report 5 responds to Resolution 907-I-16, introduced by the Resident and Fellow Section and referred by the House of Delegates. Resolution 907 asked that our AMA amend existing policies, however, the evidence available at this time does not support a substantial change in the AMA’s policy on cannabis. Ongoing surveillance to determine the impact of cannabis legalization and commercialization on public health and safety will be critical. The Council on Science
and Public Health recommends that the following statements be adopted in lieu of Resolution 907-I-16 and the remainder of the report be filed:


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

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

3. That the following new policy be adopted:

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

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

H-95.952, "Cannabis Research for Medicinal Use"
(1) Our AMA calls for further adequate and well-controlled studies of marijuana and related cannabinoids in patients who have serious conditions for which preclinical, anecdotal, or controlled evidence suggests possible efficacy and the application of such results to the understanding and treatment of disease. (2) Our AMA urges that marijuana's status as a federal schedule I controlled substance be reviewed with the goal of facilitating the conduct of clinical research and development of cannabinoid-based medicines, and alternate delivery methods. This should not be viewed as an endorsement of state-based medical cannabis programs, the legalization of marijuana, or that scientific evidence on the therapeutic use of cannabis meets the current standards for a prescription drug product. (3) Our AMA urges the National Institutes of Health (NIH), the Drug Enforcement Administration (DEA), and the Food and Drug Administration (FDA) to develop a special schedule and implement administrative procedures to facilitate grant applications and the conduct of well-designed clinical research involving cannabis and its potential medical utility. This effort should include: a) disseminating specific information for researchers on the development of safeguards for cannabis clinical research protocols and the development of a model informed consent form for institutional review board evaluation; b) sufficient funding to support such clinical research and access for qualified investigators to adequate supplies of cannabis for clinical research purposes; c) confirming that cannabis of various and consistent strengths and/or placebo will be supplied by the National Institute on Drug Abuse to investigators registered with the DEA who are conducting bona fide clinical research studies that receive FDA approval, regardless of whether or not the NIH is the primary source of grant support. (4) Our AMA believes that effective patient care requires the free and unfettered exchange of information on treatment alternatives and that discussion of these alternatives between physicians and patients should not subject either party to criminal sanctions. Our AMA supports research to determine the consequences of long-term cannabis use, especially among youth, adolescents, pregnant women, and women who are breastfeeding. (5) Our AMA urges legislatures to delay initiating the legalization of cannabis for recreational use until further research is completed on the public health, medical, economic, and social consequences of its use. (Modify Current HOD Policy)

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

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

Resolution 915 asks that our American Medical Association work with the National Institutes of Health to advocate for easing the barriers to medical research regarding chemical components of marijuana such as cannabidiol that show great promise.

Your Reference Committee heard testimony that was largely supportive of the Council’s recommendations on cannabis. Those in support of the Council’s recommendations
noted that cannabis products for medicinal use should be approved by the FDA and not through the state legislative or ballot measure process. Limited testimony questioned whether cannabis is a dangerous drug and noted concern with the AMA opposing the legalization of cannabis for medicinal purposes through the state legislative or ballot measure process. Your Reference Committee agreed that the word “oppose” could be modified while still capturing the original intent of the statement. There was broad support for continued research on the health effects of cannabis, public health surveillance in states that have legalized cannabis use, and allocating cannabis tax revenue to public health programs. Your Reference Committee believes that Resolution 915 is covered in existing Policy H-95.952 on cannabis research, but supports amending the title of that policy to better reflect our AMA’s advocacy for easing barriers to medical research regarding cannabinoids, such as cannabidiol. Therefore, your Reference Committee recommends that the recommendations in CSAPH Report 5 be adopted as amended in lieu of Resolution 915.

(10) RESOLUTION 901 – HARMFUL EFFECTS OF SCREEN TIME IN CHILDREN

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 901.

RESOLVED, That our AMA encourage primary and secondary 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 our AMA encourage primary care physicians to assess pediatric patients and educate parents about amount of screen time, physical activity and sleep habits. (New HOD Policy)

Resolution 901 asks that our American Medical Association 1.) encourage all schools to incorporate into health class curriculum the topic of balancing screen time with physical activity and sleep; 2.) encourage research into the utility of blue light filtering glasses and a blue light filter option on devices such as smart phones and tablets; and 3.) encourage physicians to assess all patients and educate all parents about amount of screen time, physical activity and sleep habits.

Your Reference Committee heard testimony detailing the need for increased physical activity and the importance of balancing the amount of time spent viewing digital devices and being active, and the need to incorporate this education into schools. An alternative resolution was offered by the sponsors and was largely supported. Therefore, your Reference Committee recommends that alternate Resolution 901 be adopted.
(11) RESOLUTION 902 – EXPANDING EXPEDITED PARTNER THERAPY TO TREAT TRICHOME NIASIS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 902 be amended 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, and other sexually transmitted infections, as supported by scientific evidence and identified by the CDC. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 902 be adopted as amended.

Resolution 902 asks 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.

Your Reference Committee heard testimony supportive of Resolution 902. Since Trichomoniasis is easily treatable with a single dose of antibiotics there was support for the use of expedited partner therapy (EPT). The CDC’s 2015 sexually transmitted diseases treatment guidelines suggest that EPT might have a role in partner management for Trichomoniasis. However, no single partner management intervention has been shown to be more effective than any other in reducing Trichomoniasis reinfection rates. An amendment was proposed to include other STIs as identified by the Centers for Disease Control to preclude having to add additional STIs as more evidence becomes available. Your Reference Committee believes that supporting the use of EPT for STIs, as supported by scientific evidence and the CDC, accomplishes the intent of the resolution. Therefore, Your Reference Committee recommends that Resolution 902 be adopted as amended.
(12) RESOLUTION 903 – IMPROVING SCREENING AND TREATMENT GUIDELINES FOR DOMESTIC VIOLENCE AGAINST LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING, AND OTHER INDIVIDUALS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 903 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association study publish an update to its 1992 Diagnostic and Treatment Guidelines on Domestic Violence to reflect recent domestic violence data and to address the unique issues faced by the LGBTQ+ population (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 903 be amended by deletion to read as follows:

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

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the third Resolve of Resolution 903 be amended by deletion to read as follows:

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
RECOMMENDATION D:

Madam Speaker, your Reference Committee recommends that the fourth Resolve of Resolution 903 be amended by deletion to read as follows:

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-160.9911. 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, 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)

RECOMMENDATION E:

Madam Speaker, your Reference Committee recommends that Resolution 903 be adopted as amended.

Resolution 903 asks that our American Medical Association 1.) 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; 2.) promote crisis resources for LGBTQ+ patients that cater to the specific needs of LGBTQ+ victims of domestic violence; 3.) 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

and 4.) 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, and 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.

Your Reference Committee heard testimony largely in support of Resolution 903. It was recognized that many groups within the LGBTQ population experience intimate partner violence at least as frequently as heterosexual women, who are the focus of most screening and intervention efforts. The sponsors offered an amendment to the first Resolve statement encouraging the AMA to study the issue rather than revise the 1992 guidelines. Your Reference Committee agrees with that amendment. Your Reference Committee also agrees with using the term LGBTQ rather than LGBTQ+, to be consistent with AMA policy per the testimony from the AMA LGBTQ advisory committee stating that there is a lack of consensus on use of the plus sign at this time. Therefore, your Reference Committee recommends that Resolution 903 be adopted as amended.

(13) RESOLUTION 904 – EDUCATING PHYSICIANS ABOUT THE IMPORTANCE OF CERVICAL CANCER SCREENING FOR FEMALE-TO-MALE TRANSGENDER PATIENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 904 be amended by addition and deletion 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 sexual and gender minority individuals who have sex with women and female-to-male transgender patients when medically indicated to undergo regular cancer and sexually transmitted infection screenings based on anatomy 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. (Modify Current HOD
Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends
that Resolution 904 be adopted as amended.

Resolution 904 asks that our American Medical Association amend Policy H-160.991 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.

Your Reference Committee heard testimony unanimously in support in this resolution.
Comments detailed the high rate of cervical cancer risk for individuals with a cervix. An
amendment was offered to focus on anatomy rather than listing of possible individuals,
with which your Reference Committee agrees. Therefore, your Reference Committee
recommends that Resolution 904 be adopted as amended.

(14) RESOLUTION 905 – ADDRESSING SOCIAL MEDIA
USAGE AND ITS NEGATIVE IMPACTS ON MENTAL
HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that the first Resolve of Resolution 905 be amended by
addition and deletion to read as follows:

RESOLVED, That our American Medical Association
collaborate with relevant professional organizations to (a)
support the development of continuing education programs
to enhance physicians’ knowledge of the health impacts of
social media usage, and (b) support the development of
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
RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 905 be adopted as amended.

Resolution 905 asks 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; and 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.

Your Reference Committee heard testimony largely in support of Resolution 905. Many commenters spoke of broad health impacts, both negative and positive and not just mental health related, from social media usage, as well as social media over-use. The idea of education programs was well-received. However, many commented that our AMA developing clinical tools and protocols is outside of the scope of the organization and are tasks that are better suited for specialized organizations. Therefore, your Reference Committee recommends that Resolution 905 be adopted as amended.

(15) RESOLUTION 906 – OPIOID ABUSE IN BREASTFEEDING MOTHERS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 906 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association’s Opioid Task Force to Reduce Opioid Abuse promote educational resources for opioid dependent mothers who are breastfeeding on the benefits and risks of breastfeeding while using prescription opioids or during medication-assisted maintenance therapy for opioid use disorder, based on the most recent guidelines.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 906 be adopted as amended.
RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 906 be changed to read as follows:

BREASTFEEDING IN MOTHERS WHO USE OPIOIDS

Resolution 906 asks 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; and 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.

Consistent and compelling testimony was offered in support of this resolution. Several members noted the importance of providing evidence-based care for the treatment of opioid use disorder in women of childbearing age and in those who are pregnant or breastfeeding. Clear guidance exists to assist clinical decision-making in such patients. The benefits that accrue from breastfeeding in this population are established, but a significant educational gap is apparent, and disparities are common. A suggestion was made to expand the topic of this resolution to specifically include incarcerated populations. While an important issue, your Reference Committee believes it has other dimensions that need to be considered. Your Reference Committee recommends adoption with some editorial and terminology changes, as well as a change in title.
RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 907 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care system children. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 907 be adopted as amended.

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the title of Resolution 907 be changed to read as follows:

ADDRESSING HEALTHCARE NEEDS OF CHILDREN IN FOSTER CARE

Resolution 907 asks that our American Medical Association advocate for comprehensive and evidence-based care that addresses the specific health care needs of foster care children.

Your Reference Committee heard testimony unanimously in support of this resolution. It was noted that there are more than 400,000 children in foster care and that advocacy is needed to help this population. Therefore, your Reference Committee recommends that Resolution 907 be adopted as amended.
(17) RESOLUTION 908 – UPDATE ENERGY POLICY AND EXTRATION REGULATIONS TO PROMOTE PUBLIC HEALTH AND SUSTAINABILITY

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 908 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA support research on the implementation of buffer zones or well set-backs between oil and gas development sites and residences, schools, hospitals, and religious institutions, to determine the distance necessary to ensure public health and safety.

(New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 908 be adopted as amended.

Resolution 908 asks that our AMA amend policy H-135.949 by insertion 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.

and that our AMA support the implementation of buffer zones between oil and gas development sites and residences, schools, hospitals, and religious institutions.

Your Reference Committee heard mostly supportive testimony on Resolution 908. Some concerns were raised regarding buffer zones and the lack of data available on the minimum well set-backs necessary to protect public health and safety. Your Reference Committee agrees that more research is needed and therefore recommends that Resolution 908 be adopted as amended.
(18) RESOLUTION 909 – EXPANDING NALOXONE PROGRAMS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 909 be amended by addition to read as follows:

RESOLVED, That our American Medical Association urge the Food and Drug Administration to 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)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 909 be adopted as amended.

Resolution 909 asks 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).

Substantial testimony was expressed for the concept of this resolution, and the value of having the AMA study the issue in an effort to move it forward. The AMA already has strong policy in support of expanded access to naloxone through community-based efforts, physician standing orders, and co-prescribing. An analogy with community-based external automated defibrillators was advanced. While this concept is appealing, given the need to expand access to naloxone in this country, several potential barriers and requisite steps were noted, including: (1) the need for the FDA to regulate this practice and approve over-the-counter availability of a naloxone product that would be suitable for placement in a public setting and amenable to untrained bystander use; (2) a requirement for stability testing, expiration dating, and product replacement; (3) the need to place the product for maximum effectiveness; and, (4) security requirements appropriate to a publicly available antidote that is in high demand and expensive. For all these reasons, your Reference Committee believes a cycle of FDA review would be prudent before committing AMA resources to evaluating or attempting to understand how such a program might be implemented.
RESOLUTION 912 – CORRECTIVE STATEMENTS
ORDERED TO BE PUBLISHED BY TOBACCO COMPANIES FOR THE VIOLATION OF THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 912 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association collaborate with state and medical specialty societies, component societies, and other interested public health organizations such as the Campaign for Tobacco Free Kids, Truth Initiative, the American Cancer Society, the American Lung Association and the American Heart Association, to help educate the public and policymakers about the tobacco companies’ organized conspiracy to commit fraud leading to the federal court verdict finding them in violation of the Racketeer Influenced and Corrupt Organization Act (RICO) and resulting in the corrective statements as ordered by the U.S. Court of Appeals in United States v. Philip Morris (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 912 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA encourage state and medical specialty—our component societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly— influenced by tobacco companies or their lobbyists and encourage lawmakers to remediate all such influences, to reject any potential tobacco industry influences in the future, and to formally censure the tobacco companies for their fraudulent and harmful behavior. (Directive to Take Action)
RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends
that Resolution 912 be adopted as amended.

Resolution 912 asks that our American Medical Association collaborate with members, component societies, and other interested public health organizations such as the Campaign for Tobacco Free Kids, Truth Initiative, the American Cancer Society, the American Lung Association and the American Heart Association, to help educate the public and policymakers about the tobacco companies' organized conspiracy to commit fraud leading to the federal court verdict finding them in violation of the Racketeer Influenced and Corrupt Organization Act (RICO) and resulting in the corrective statements as ordered by the U.S. Court of Appeals in United States vs. Philip Morris; and that our AMA encourage our component societies to work with appropriate public health organizations in their states to help identify public policies that may have been directly or indirectly influenced by tobacco companies or their lobbyists and encourage lawmakers to remediate all such influences, to reject any potential tobacco industry influences in the future, and to formally censure the tobacco companies for their fraudulent and harmful behavior.

Your Reference Committee heard testimony in strong support of Resolution 912. Due to RICO violations, cigarette manufacturers will begin making corrective statements on topics about which they had historically deceived the public. The content of these corrective statements has been the subject of litigation for nearly two decades. This resolution will help raise awareness regarding these corrective statements. The amendments remove reference to any specific stakeholder organizations and clarify that the term component societies refers to state and medical specialty societies. Therefore, your Reference Committee recommends that Resolution 912 be adopted as amended.

(20) RESOLUTION 914 – SUPPORT OF TRAINING, ONGOING EDUCATION, AND CONSULTATION IN ORDER TO REDUCE THE HEALTH IMPACT OF PEDIATRIC ENVIRONMENTAL CHEMICAL EXPOSURES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 914 be amended by deletion of the third Resolve.

RESOLVED, That our AMA encourage the continuing training of physicians specializing in pediatric environmental health. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 914 be adopted as amended.
Resolution 914 asks that our American Medical Association 1.) support the mission of and ongoing funding of academically-based regional Pediatric Environmental Health Specialty Units (PEHSU) by the Agency for Toxic Substances and Disease Registry of the Centers for Disease Control and Prevention (ATSDR/CDC) and the Environmental Protection Agency (EPA); 2.) support educational and consultative activities of the PEHSU program with local pediatricians, medical toxicologists, obstetricians, and others providing care to pregnant patients; and 3.) encourage the continuing training of physicians specializing in pediatric environmental health.

Limited but supportive testimony was offered on this resolution. A recommendation was made to delete the third resolve to avoid a continual evolution of specific training requests that may be submitted to the House of Delegates for deliberation. Your Reference Committee concurs.

(21) RESOLUTION 916 – HOSPITAL DISASTER PLANS AND MEDICAL STAFFS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 916 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA: (1) work with encourage appropriate stakeholders to examine the barriers and facilitators that medical staffs will encounter following a natural or other disaster; and (2) encourage hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff responses during a natural or other disaster, both within their institutions and across the community (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 916 be adopted as amended.

Resolution 916 asks that our American Medical Association: (1) work with appropriate stakeholders to examine the barriers and facilitators that medical staffs encounter following a natural or other disaster; and (2) encourage hospitals to incorporate, within their hospital disaster plans, workplace and personal preparedness efforts that reduce barriers to staff response during a natural or other disaster, both within their institutions and across the community.

Your Reference Committee heard limited, but supportive testimony for Resolution 916. There was consensus that people need to be involved in planning before disaster strikes and current AMA policy does not address personal preparedness for medical staffs. Your Reference Committee is aware that there are multiple stakeholders engaged and working in this area already. The AMA is best suited to encourage them to address
these issues. Therefore your Reference Committee recommends that 916 be adopted as amended.

(22) RESOLUTION 952 – IMPLICIT BIAS, DIVERSITY AND INCLUSION IN MEDICAL EDUCATION AND RESIDENCY TRAINING

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 952 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association: (1) actively support the development and implementation of training regarding 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 related to race, ethnicity, and all populations at increased risk according to race and ethnicity, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; 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 in all at-risk populations. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 952 be adopted as amended.

Resolution 952 asks 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.

Your Reference Committee heard universally supportive testimony for the intent of Resolution 952. Delegates noted the importance of recognizing the effects of implicit bias, diversity, and inclusion, and stressed the urgent need to address these concerns at multiple levels. Testimony also recognized the work currently being done in this area by members of the AMA’s Accelerating Change in Medical Education consortium.
Additional testimony elicited the fact that biases can be bidirectional in nature, and that patients and lay caregivers can also harbor/be affected by these types of biases.

Testimony heard in Reference Committee is in line with existing AMA policy. Policy H-350.974, “Racial and Ethnic Disparities in Health Care,” recognizes racial and ethnic health disparities as a major public health problem in the United States; Policy H-295.897, “Enhancing the Cultural Competence of Physicians,” encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency and the combining of knowledge of health disparities and practice of cultural competence with clinical skills; Policy 350.991, “Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities,” encourages all members of the federation to embrace principles related to ending care disparities; and D-350.996, “Strategies for Eliminating Minority Health Care Disparities,” asks our AMA to continue to identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts.


Several friendly amendments were proposed, which your Reference Committee feels help to clarify and strengthen the resolution. Therefore, your Reference Committee recommends that Resolution 952 be amended by addition and deletion.

(23) RESOLUTION 953 – FEES FOR TAKING MAINTENANCE OF CERTIFICATION EXAMINATION

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policy H-275.924 (19), Maintenance of Certification, be amended in lieu of Resolution 953 to read as follows:

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not be cost prohibitive or present barriers to patient care.

Resolution 953 asks 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.

Your Reference Committee heard mixed testimony related to the fee for the MOC Part III examination. Some felt that the cost of the examination was onerous and a burden for physicians, and that there was a lack of clinical relevance and evidence to support
efficacy as well as high fees to participants. There was also concern about the equity of
the fee structure of MOC established by the specialty boards, since some specialty
boards have adopted or are considering the adoption of reduced fee structures for MOC,
while other boards have not. Testimony also pointed out that due to the Council on
Medical Education’s continued dialogue and collaboration with the American Board of
Medical Specialties and its member boards, there has been progress in addressing AMA
member concerns about the MOC examination. About half of the ABMS member boards
have taken steps to make the examination more constructive and less onerous for
physicians. The boards are also addressing issues of convenience, relevance, and cost.
This is a complex issue that the Council continues to proactively engage in with the
member board community to achieve a more meaningful process for physicians and
reports to the HOD annually. It was also noted that similar existing HOD policy could be
modified to support the intent of this resolution. Therefore, your Reference Committee
recommends that Policy H-275.924 (19), “Maintenance of Certification,” be amended in
lieu of Resolution 953.

(24) RESOLUTION 954 – DEVELOPING PHYSICIAN LED
PUBLIC HEALTH/POPULATION HEALTH CAPACITY IN
RURAL COMMUNITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends
that Resolution 954 be amended by addition and deletion
to read as follows:

RESOLVED, That our American Medical Association
study, with the participation of the appropriate educational
and certifying entities, encourage the study of innovative
approaches that could be developed and/or implemented
to promote support interested physicians to obtain board
eligibility as they seek qualifications and credentials in
preventive medicine/public health to strengthen public
health leadership, especially in rural communities.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends
that Resolution 954 be adopted as amended.

Resolution 954 asks 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.

Your Reference Committee heard testimony in overall support of Resolution 954 and the
need for flexible approaches to enhance the leadership of physicians in public health
and preventive medicine. Additional testimony, while in support of the resolution’s intent,
reflected that the American Board of Preventive Medicine already has in place numerous alternative pathways to achieve these aims and ensure flexibility. Others noted that the need for leadership in public health is acute in urban as well as rural areas, and that more women are needed in these roles, in light of the panoply of health issues affecting female patients. Comments were also heard in opposition to the term “board eligibility.” Your Reference Committee believes that the emendations proffered by the Council on Medical Education, and deletion of the term “board eligibility,” strengthen this proposed policy, and thereby recommend adoption as amended.

(25) RESOLUTION 955 – MINIMIZATION OF BIAS IN THE ELECTRONIC RESIDENCY APPLICATION SERVICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 955 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for the formation of an encourage the Association of American Medical Colleges (AAMC) and its Electronic Residency Application Service (ERAS) Residency Application Bias Minimization Advisory Committee to develop steps to minimize bias in the ERAS and the examine this role of bias in residency training selection process. (Directive to Take Action); and be it further

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that the second Resolve of Resolution 955 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA advocate for the that modifications of the ERAS Residency Application to minimize its bias consider the effects these changes may have on efforts to increase diversity in residency programs in accordance with the suggestions of the ERAS Residency Application Bias Minimization Committee. (Directive to Take Action)

RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that Resolution 955 be adopted as amended.
Resolution 955 asks that our American Medical Association advocate for the formation of an Electronic Residency Application Service (ERAS) Residency Application Bias Minimization Committee to examine this role of bias in residency training selection process; and 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.

Your Reference Committee heard strong support for the intent of this resolution, and many stressed the AMA’s ability to send a message of support for minimization of bias and enhancement of diversity in the physician workforce. Existing AMA policy is supportive of the intent of Resolution 955. Policies H-310.976, “Gender-Based Questioning in Residency Interviews,” D-255.982, “Oppose Discrimination in Residency Selection Based on International Medical Graduate Status,” and H-310.919, “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,” oppose residency interview questions/candidate selection based on gender, IMG status, marital status/plans for marriage or children, sexual orientation, age, race, national origin, and religion. D-200.985, “Strategies for Enhancing Diversity in the Physician Workforce,” states that the AMA will work to advocate for tracking and reporting of demographic information pertaining to underrepresented minority status collected by the ERAS applications through the NRMP. D-310.977, “National Resident Matching Program Reform,” states that our AMA will work with the NRMP and other external bodies to develop mechanisms that limit disparities within the residency application process and allow both flexibility and standard rules for applicants.

Testimony did elicit that the AAMC has an existing ERAS Advisory Committee, and it was felt that it would be appropriate for this existing body, not a new group, to develop steps to minimize bias in the ERAS and residency training selection process. A friendly amendment was suggested to acknowledge the existence of this committee. A second amendment was proffered that any proposed modifications be reviewed to consider the effects these changes might have on efforts to increase diversity in residency programs.

Referral was mentioned as a possible option, because of the complexity of this topic. However, your Reference Committee feels that as an appropriate body located within the AAMC already exists to address these types of issues, the AMA does not need to perform its own, separate study. Therefore, your Reference Committee recommends that Resolution 955 be adopted as amended.

(26) RESOLUTION 957 – STANDARDIZATION OF FAMILY PLANNING TRAINING OPPORTUNITIES IN OB-GYN RESIDENCIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the first Resolve of Resolution 957 be amended by addition to read as follows:
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 requirements set forth by the Review Committee for Obstetrics and Gynecology and the American Congress of Obstetricians and Gynecologists’ recommendations. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 957 be adopted as amended.

Resolution 957 asks 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.

Your Reference Committee heard testimony universally in support of the intent of this resolution. Multiple delegations stressed the importance of high-quality training that produces physicians capable of fully practicing in their specialty. Other testimony noted that full training of this nature is essential to protect women’s health, especially in rural and underserved areas. Testimony also acknowledged that the resolution focuses solely on a training issue, and that any individual physician can choose not to perform a particular procedure based on a personal objection.

Amended language was proposed that would clarify that this type of compliance is monitored by the ACGME’s Review Committee for Obstetrics and Gynecology, and the resolution’s language should acknowledge this body’s authority. ACGME Review Committees may also take into consideration recommendations made by the relevant specialty societies. Your Reference Committee agrees that the proposed amended language helps to elucidate the intent of this resolution, and further notes that the revised language reinforces the governing body’s purview in this area.

Existing AMA policy is supportive of the wording of the revised language. H-295.923, “Medical Training and Termination of Pregnancy,” notes that 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. H-295.915, “Residency Program Responsibility,” notes that 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.

Therefore, your Reference Committee recommends that Resolution 957 be adopted as amended.
(27) RESOLUTION 958 – SEX AND GENDER BASED MEDICINE IN CLINICAL MEDICAL EDUCATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that first Resolve of Resolution 958 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association collaborate with 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 disseminate the work produced by medical schools participating in the Accelerating Change in Medical Education consortium and distribute pertinent information and a comprehensive bibliography about the assurance of inclusion of influence that sex and gender have upon clinical medicine. Based medicine in medical education programs across the spectrum of learners nationwide. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 958 be adopted as amended.

Resolution 958 asks 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.

Your Reference Committee heard testimony indicating that delegates are aware of the literature showing that potential bias may be inherent within medical trials, and that some trials (including drug studies) may be identified through disclosures that testing populations may have a skewed representation of specific gender and sexual traits. A number of medical schools that participated in the recent Accelerating Change in Medical Education (ACE) conference, held in Chicago in September 2017, presented work in these areas, and work being done in this regard should be disseminated to a broad and comprehensive audience of valued stakeholders in order to increase awareness of the scientific bias that some studies may have inherent in their research methods. At the same time, the AMA should be sensitive to the right of individual medical schools to determine their own curricular content.
Substitute language was proposed that highlights the related work of the ACE consortium and proposes the dissemination of pertinent literature related to the concerns identified by the resolution.

Existing AMA policy is relevant to the intent of this resolution. AMA Policy H-525.976, “An Expanded Definition of Women's Health,” states that 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.

Policy H-295.890 (1, 5, and 6), “Medical Education and Training in Women's Health,” asks that our AMA encourage the coordination and synthesis of the knowledge, skills, and attitudinal objectives related to women’s health/gender-based biology that have been developed for use in the medical school curriculum. Medical schools should include attention to women’s health throughout the basic science and clinical phases of the curriculum; encourage the development of a curriculum inventory and database in women’s health for use by medical schools and residency programs; encourage physicians to include continuing education in women’s health/gender based biology as part of their continuing professional development.

Therefore, your Reference Committee recommends that Resolution 958 be amended by addition and deletion.

(28) RESOLUTION 959 – LIFESTYLE MEDICINE EDUCATION IN MEDICAL SCHOOL TRAINING AND PRACTICE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 959 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association explore pathways support legislation that incentivizes and/or provides funding for the inclusion of lifestyle medicine education and social determinants of health in undergraduate medical school education, graduate medical education and continuing medical education, including but not limited to education in nutrition, physical activity, behavior change, sleep health, tobacco cessation, alcohol use reduction, emotional wellness, and stress reduction.

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 959 be adopted as amended.
Resolution 959 asks that our American Medical Association support legislation that incentivizes and/or provides funding for the inclusion of lifestyle medicine education in medical school education, graduate medical education, and continuing medical education, including but not limited to education in nutrition, physical activity, behavior change, sleep health, tobacco cessation, alcohol use reduction, emotional wellness, and stress reduction.

Your Reference Committee heard mixed testimony on Resolution 959, reflecting concerns with legislative interference in medical education curricula. Other testimony was heard that the resolution, if adopted as policy, could have unintended consequences, including development of lifestyle medicine as its own separate specialty field of medicine. In addition, the laundry list of public health issues in the resolution was seen as problematic, in that it was not all-inclusive—and any attempt to make it so would be difficult, if not impossible. Your Reference Committee supports the edits provided by the Academic Physicians Section—which remove the reference to legislation from the resolution and incorporate the phrase “social determinants of health”—and allow our AMA to pursue a more measured and judicious approach to this complex issue. Therefore, your Reference Committee recommends adoption as amended.

(29) RESOLUTION 960 – MEDICAL STUDENT INVOLVEMENT AND VALIDATION OF THE STANDARDIZED VIDEO INTERVIEW IMPLEMENTATION

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 960 be amended by addition of a third Resolve to read as follows:

RESOLVED, That our AMA, in collaboration with the Association of American Medical Colleges, study the potential implications and repercussions of expanding the Standardized Video Interview to all residency applicants. (Directive to Take Action)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 960 be adopted as amended.

Resolution 960 asks that our AMA work with the Association of American Medical Colleges and its partners to advocate for medical students and residents to be recognized as equal stakeholders in any changes to the residency application process, including any future working groups related to the residency application process; and that the AMA advocate for delaying expansion of the Standardized Video Interview until data demonstrates the Association of American Medical Colleges’ stated goal of predicting resident performance, and make timely recommendations regarding the efficacy and implications of the Standardized Video Interview as a mandatory residency application requirement.
Your Reference Committee heard extensive testimony on Resolution 960, an issue of critical concern to medical students, as reflected by its immediately forwarding from the Medical Student Section to the House of Delegates at this Interim Meeting. Multiple concerns were cited in testimony, including as of yet insufficient data supporting a wider rollout of the Standardized Video Interview (SVI) to all medical students (beyond the current pilot in emergency medicine); the potential for racial or ethnic biases; increased costs to students; and a possible digital divide between the technology cognoscenti and the have-nots. The concern that the Association of American Medical Colleges could rapidly expand the SVI to all fields heightens the need for immediate action. Others, including the Council on Medical Education, urged for referral, to allow for sufficient time to review the SVI and its ramifications for residency applicants and programs alike. Your Reference Committee believes its proposed addition of a third Resolve, calling for our AMA to study this complex and deeply concerning issue, serves to meet the needs of both sides of the debate, with immediate action—through AMA policy and advocacy—as well as further review and rumination on the SVI. Therefore, your Reference Committee recommends adoption of Resolution 960 as amended.

(30) RESOLUTION 956 – HOUSE PHYSICIANS CATEGORY

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 956 not be adopted.

Resolution 956 asks 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.

Your Reference Committee heard strong opposition to Resolution 956. This resolution is not consistent with AMA policy, which opposes special licensing pathways for physicians who are not currently enrolled in an Accreditation Council for Graduate Medical Education or American Osteopathic Association training program, or have not completed at least one year of accredited graduate medical education (GME) in the United States. It was also noted this could result in potential abuse of individuals working in this capacity, and would be of concern to state medical boards—to say nothing of the potential for patient safety concerns for a “subclass” of practitioners, and the subversion of physicians’ arguments against scope of practice incursions by nonphysicians. Further, some felt that the hospital employment requirement (if extended to other states) would not necessarily greatly improve the physician shortage problem and could be counterproductive to the AMA’s advocacy for additional GME slots. This resolution could also circumvent the requirements of passing the United States Medical Licensing Examination Step 3 as well as completing the required number of years of GME in the U.S.—all of which are requirements expected from U.S. medical graduates before practicing clinical medicine. Therefore, your Reference Committee recommends that Resolution 956 not be adopted.
Madam Speaker, this concludes the report of Reference Committee K. I would like to thank Gary A. Delaney, MD, Michael A. DellaVecchia, MD, PhD, Melody Eckardt, MD, Laura Halpin, MD, PhD, Ronit Katz, MD, Joseph R. Sellers, MD, all those who testified before the Committee as well as our AMA staff.

Gary A. Delaney, MD
South Carolina

Laura Halpin, MD, PhD
Resident and Fellow Section

Michael A. DellaVecchia, MD, PhD
(Alternate)
Pennsylvania

Ronit Katz, MD (Alternate)
International Medical Graduates Section

Melody Eckardt, MD (Alternate)
Massachusetts

Joseph R. Sellers, MD
New York

L. Samuel Wann, MD
American College of Cardiology
Chair